New Patient Ophthalmology Information

Date:_____ Patient Name: _____

Date of Birth: _____ SS#: _____

Preferred Language: ☐ English ☐ Other _____

Race: ☐ White ☐ Black ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

I was referred by: Physician: _____ Family/Friend: _____

Pharmacy Name & Phone: _____

PLEASE ANSWER *ALL* QUESTIONS:

What is your reason for today's visit? Check all that apply: eye exam for ☐ cataracts ☐ glaucoma ☐ eye injury ☐ diabetic eye exam ☐ macular degeneration ☐ cornea problems ☐ check prescription for glasses / contact lenses ☐ Other _____

Are you interested in LASIK or Refractive surgery? ☐ Yes ☐ No

Please describe any specific problem(s): _____

When did this problem / pain start? _____

Where is the problem / pain located? _____

What makes this problem / pain worse? _____

If there any other symptoms associated with this problem / pain? Please describe: _____

On a scale of 1-10 (10 being worst), How severe or disabling is this problem? _____

Does anything make the problem/pain better? (Medications, drops, activities) _____

Is there any time of the day when this problem/pain is worse?_____

_____

General Review of Systems: Do you currently have any of the following ?

Diabetes?	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Weight Loss?	☐ Yes	☐ No
Heart Problems?	☐ Yes	☐ No	Skin Problems or Rashes?	☐ Yes	☐ No
Breathing Problems?	☐ Yes	☐ No	Urinary or Genital Problems?	☐ Yes	☐ No
Stomach or Intestinal Problems?	☐ Yes	☐ No	Neurologic complaints	☐ Yes	☐ No
Arthritis or Joint Problems?	☐ Yes	☐ No	i.e.: Stroke, Seizure, Weakness		
Ear, Nose or Throat Problems?	☐ Yes	☐ No	Bleeding Tendencies?	☐ Yes	☐ No
Allergies?	☐ Yes	☐ No	Psychiatric Illness?	☐ Yes	☐ No

Please list your current medications, including over the counter medication and herbal supplements:

1._____ **6.** _____
2._____ **7.** _____
3._____ **8.** _____
4._____ **9.** _____
5._____ **10.** _____

Continued on other side

Please list any allergies to medications: _____

My <u>Past</u> Medical includes:

☐ High blood pressure ☐ Diabetes ☐ Kidney Disease ☐ Lung Problems
☐ Heart Disease ☐ High Cholesterol ☐ Cancer ☐ Stroke
☐ Heart Valve Problems

Do ***you***: ☐ Smoke ☐ Drink Alcohol ☐ Use Drugs ☐ Take Aspirin Products

Occupation _____
Hobbies _____

Family Medical History (Family includes parents, grandparents, siblings, aunts, uncles)

☐ Glaucoma ☐ Crossed Eyes ☐ Macular Degeneration ☐ Retinal detachment
☐ Diabetes ☐ Cataract before age 60 ☐ Other eye disease

Please list your eye history: *(Give approximate dates for surgeries / hospitalizations)*

Eye Surgeries / Approx. Date	**Medical Eye Diseases / When diagnosed**

Ophthalmology Review of Systems: Are you currently having, or have history of, any of the following:

☐ Blurred Vision ?	☐ Right Eye	☐ Left Eye	☐ Both Eyes_____
☐ Glare ?	☐ Right Eye	☐ Left Eye	☐ Both Eyes_____
☐ Difficulty with headlights?	☐ Right Eye	☐ Left Eye	☐ Both Eyes_____
☐ Difficulty with driving?	☐ Right Eye	☐ Left Eye	☐ Both Eyes_____
☐ Difficulty with night vision?	☐ Right Eye	☐ Left Eye	☐ Both Eyes_____
☐ Difficulty with other visual tasks?	Explain_____		
	_____		
☐ Double Vision?	☐ Right Eye	☐ Left Eye	☐ Both Eyes_____
☐ Distortion in vision?	☐ Right Eye	☐ Left Eye	☐ Both Eyes_____
☐ Eye Redness ?	☐ Right Eye	☐ Left Eye	☐ Both Eyes_____
☐ Eye Discharge?	☐ Right Eye	☐ Left Eye	☐ Both Eyes_____
☐ Eye Pain ?	☐ Right Eye	☐ Left Eye	☐ Both Eyes_____
☐ Itching Eyes?	☐ Right Eye	☐ Left Eye	☐ Both Eyes_____
☐ Foreign Body Sensation?	☐ Right Eye	☐ Left Eye	☐ Both Eyes_____
☐ Drooping eye lid?	☐ Right Eye	☐ Left Eye	☐ Both Eyes_____
☐ Crossed eye?	Right Eye_____	Left Eye_____	Both Eyes_____
☐ Trauma to eye?	Right Eye_____	Left Eye_____	Both Eyes_____
☐ Tearing?	Right Eye_____	Left Eye_____	Both Eyes_____
☐ Light Sensitivity?	Right Eye_____	Left Eye_____	Both Eyes_____
☐ Lesion on eye or eyelid ?	Right Eye_____	Left Eye_____	Both Eyes_____
☐ Change in pupil size?	Right Eye_____	Left Eye_____	Both Eyes_____

X_____ _____
Patient Signature Physician Signature