MID ISLAND EYE
PHYSICIANS & SURGEONS

New Patient History

Date _____ Date of Birth _____ Age _____ Sex _____
Patient Name _____ Marital Status: S M W D Occupation _____
Allergies: Medicinal/Other _____
Current Medications _____
_____

TESTS AND IMMUNIZATIONS

	Yes	Year Done		Yes	Year Done
Complete Physical			Tetanus (DPT)		
Fasting Blood Sugar			Hearing Test		
Vision Test			Flu Shot		
Other					

PERSONAL & FAMILY HISTORY

Have You or Any Relative Had Any Problems With:	Self			Family			
	No	Yes	When	No	Yes	When	Who
Constitutional (fever/weight loss / other) **Explanation:**							
Eyes (cataract/glaucoma/vision disturb/dbl vision/ other) **Explanation:**							
Ears, Nose, Throat, Mouth (nose bleeds, frequent sore throats, ear infections,/other) **Explanation:**							
Cardiovascular (chest pain/heart problems/ irreg. heart beat/ nose bleeds/ stroke/ high blood pressure/other **Explanation:**							
Respiratory (asthma/emphysema/ TB/ pneumonia /short breath/other **Explanation:**							
Gastrointestinal (abdominal bleeding /abnormal stool/colitis/GB/liver diseases/ulcer/other **Explanation:**							
Genitourinary (urinary /kidney problems/sexual problems/other **Explanation:**							
Musculoskeletal (arthritis/back/leg joint pain/Lyme disease/other) **Explanation:**							
Integumentary (rashes/moles/skin cancer/other) **Explanation:**							
Neurological (headaches/dizziness /paralysis MS/stroke/Epilepsy/other **Explanation:**							
Psychiatric (depression/nervous disorder /other) **Explanation:**							
Endocrine (diabetes/thyroid disorder /other) **Explanation:**							

Hematologic/Lymphatic (Anemia /abnormal bleeding/Leukemia/other) **Explanation:**							
Allergic/Immunologic (allergies /HIV/other) **Explanation:**							

FAMILY HISTORY

	Age at Death	Cause
Mother		
Father		
Siblings		
Grandparents		

PERSONAL HABITS

Exercise?	Smoke?
Drive?	Chew Tobacco?
Use Drugs?	Experience Stress?
Drink Alcohol?	Other

WOMEN ONLY

Menstrual Period: Age Onset _____ Difficulty with Periods?_____ Age at Menopause_____

Pregnancies: #. ____ # of children_____ Describe Complications/problems_____

MILITARY SERVICE _____

HOSPITALIZATIONS

	Description	Year
Illness (Kind)		
Surgery (Kind)		
Other (Reason)		

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING OCULAR PROBLEMS?

Problem	Yes	Explanation and date
Glaucoma		
Cataract		
Retinal Disease		
Eye Surgery		
Blurred/Distorted Vision		
Redness/Burning/Itching		
Dryness/Discharge		
Excessive Tearing		
Light Sensitivity		
Eye Infection (Blepharitis, Sty)		
Crossed Eyes/Lazy Eye (Amblyopia)		
Double Vision		
Drooping Eyelid (Ptosis)		
Other		

Please give any other insights and/or information that you feel might be helpful in your care and/or health maintenance.

_____

_____

_____

Physician's Signature _____ Date ____/____/____