New Patient Questionnaire

Name: ____________________ Date of Birth: ____/____/_____ SSN: ____________________
Address: ____________________ Primary Phone: ____________ Type (Home, Cell, etc): ________
City: ____________ State: _____ Zip: ________ Other Phone: ____________ Type (Work, Cell, etc): ________
Email: ____________________ Occupation: ____________________ Gender: M F
Guardian (if applicable): ____________________ Marital Status: ____________ Race/Ethnicity: ____________
How did you hear about us? ____________________ If referred, who may we thank? ____________________
Primary Care Physician: ____________________ Physician Address: ____________________
Physician Phone: __________ Physician Fax: __________ Date of last appointment: ____________________
Do you have Vision Insurance? ☐ Yes ☐ No If yes, who is your insurance carrier? ____________________
Do you have Medical Insurance? ☐ Yes ☐ No If yes, who is your insurance carrier? ____________________

Ocular History:

Reason For Visit: ____

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Other Vision Complaints (Please check all that apply):

	Yes	No	Unsure		Yes	No	Unsure
Blurred Vision				Diabetes Check			
Loss of Vision				Cataracts			
Double Vision				Glaucoma			
Headache				Flashes/Floaters			
Itchy or Watery Eyes				Retinal Disease			
Dryness				Eye Injury			
Foreign Body Sensation				Lazy Eye/Eye Turn			
Glare/Light Sensitivity				Other (Please describe below)			

If answered yes to any of the above complaints, please describe below: ____________________

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Please list any eyedrops or ocular medications your are currently taking: ____________________

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Please describe any eye injuries you have experienced or eye surgeries you have undergone: ____________________

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Do you wear glasses? ☐ Yes ☐ No If so, what for? ☐ Full Time ☐ Distance ☐ Reading ☐ Computer Other: ________
Do you wear contact lenses? ☐ Yes ☐ No If so, what brand? ______________ What solution? ____________
How many days per week do you wear them? ____ How many hours per day? ____ How often to you replace them? _____

From 1 to 10, how comfortable are they **when you first put them in**? 1 2 3 4 5 6 7 8 9 10

From 1 to 10, how comfortable are they **before you take them out**? 1 2 3 4 5 6 7 8 9 10

Overall, how happy would you say you are with your contact lenses? 1 2 3 4 5 6 7 8 9 10

Please turn for page 2

Medical History:

	Yes	No	Unsure		Yes	No	Unsure
Constitution				**Gastrointestinal**			
Developmental Disabilities				Chron's Disease			
Cancer				Acid Reflux			
Ear, Nose, Mouth, Throat				**Genitourinary**			
Hearing Loss				Prostate Disorder			
Sinusitis				Pregnant			
Dry Mouth				Nursing			
Neurological				Herpes/Chlamydial Infection			
Multiple Sclerosis				**Musculoskeletal**			
Cerebral Palsy				Osteoarthritis			
Tumor				Muscle/Joint Pain			
Migraine				**Integumentary**			
Psychiatric				Rosacea			
Depression				Herpes Simplex/Cold Sores			
ADD/ADHD				**Endocrine**			
Anxiety				Type 2 Diabetes			
Vascular/Cardiovascular				Type 1 Diabetes			
Hypertension/High Blood Pressure				Thyroid Dysfunction			
Stroke				**Lymphatic/Hematologic**			
Heart Disease				Anemia			
Congestive Heart Failure				High Cholesterol			
Respiratory				**Allergic/Immunologic**			
Asthma				Seasonal Allergies			
Brochitis				Rheumatoid Arthritis			
Chronic Obstructive Pulmonary Disease				Lupus			
Sleep Apnea				Sjogren's Syndrome			

If you have any condition not listed, please describe: ____

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Please list <u>ALL</u> medications you are currently taking (include oral contraceptives, aspirin, over-the-counter medications, & home remedies):		Please list any allergies you have (include medications, drops, and latex):	
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Family History:

Medical Condition	Yes	No	Unsure	Relation	Ocular Condition	Yes	No	Unsure	Relation
Cancer					Cataract				
Diabetes					Macular Degeneration				
High Blood Pressure					Glaucoma				
Thyroid Disorder					Retinal Detachment				

Social History:

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long? ________________

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long? ________________

Do you use illicit or illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long? ________________