NEW PATIENT QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Reason for visit: _____ **Referred by:** _____

How did you hear of us? _____ **Former patient:** _____

Allergies: None Penicillin Sulfa Iodine dye Codeine Other_____

Review of Systems: **Circle all that apply**

General:	headaches, fatigue
ENT:	hearing loss, nasal congestion, ringing
Respiratory:	cough, shortness of breath, wheezing
Heart:	palpitations, chest pain or pressure
GI:	constipation, diarrhea, heart burn
Bladder:	blood in urine, pain with urination
Skin:	rash, lumps, itching, dry, hives
Endocrine:	bulging eyes, cold or heat intolerance
Neuro:	imbalance, dizziness, memory loss
Psych:	nervousness, tension
Joint:	joint pain, joint stiffness, back pain
Blood:	bruising, bleeding
Immuno:	hives, seasonal allergies

Eye History:

Contact Lens
Cataract
Glaucoma
Cornea
Laser Surgery
Macular Degen.
Retina
Eye Muscle
Optic Nerve
Lids
Double Vision
Cranial Nerve
Uveitis

Eye Meds: _____

Family Eye History: Glaucoma Macular Degen. Retina Cornea Other_____

Medical History:

High blood pressure	Heart disease	Pacemaker
High cholesterol	Stroke	Heart attack
Vascular disease	Emphysema	Asthma
Diabetes I / II	Thyroid low / high	Hepatitis A/B/C
Arthritis	Osteoporosis	Gallbladder
Cancer _____	Kidney/bladder	Acid reflux
Depression	Anxiety	HIV
Anemia	Autoimmune	Seizures

Other _____

Social History: Alcohol Tobacco Recreational Drugs

Medicines:

_____
_____
_____
_____
_____
_____
_____
Aspirin 81/325mg
Coumadin
Plavix
Flomax