



NEW PATIENT QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Reason for visit: _____

How did you hear of us? _____ **Referred by:** _____

Allergies: None Penicillin Sulfa Iodine dye Codeine Other _____

Review of Systems:

Circle all that apply

Eye History:

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

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:

Medicines:

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 _____		

Aspirin 81mg / 325mg
 Coumadin / Pradaxa
 Plavix / Effient
 Flomax / Jalyn / Hytrin / Cardura

Social History: Alcohol Tobacco Recreational Drugs