NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Preferred Phone: _____

Birthdate: _____/_____/_____ Last 4 of SSN: _____ Other Phone: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Gender: _____

Guardian (if applicable): _____ Occupation: _____

How did you hear about us? _____ If referred, who may we thank? _____

Race/Ethnicity: _____ Preferred Language: _____

Primary Care Physician/Office: _____ Date of last visit: _____

Please check appropriate answers and fill in blanks:

Constitutional	**No**	**Yes**	**Unsure**
Fever, Weight Loss/Gain	☐	☐	☐
Cancer	☐	☐	☐
Ear, Nose, Mouth, Throat			
Dry Throat/Mouth	☐	☐	☐
Hearing Loss	☐	☐	☐
Sinusitis	☐	☐	☐
Neurological			
Seizures/Epilepsy	☐	☐	☐
Tension Headaches	☐	☐	☐
Migraines	☐	☐	☐
Tumor	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Psychiatric			
Anxiety/Depression	☐	☐	☐
Other	☐	☐	☐
Vascular/Cardiovascular			
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Stroke	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Sleep Apnea	☐	☐	☐
Emphysema	☐	☐	☐
Chronic Bronchitis	☐	☐	☐

Gastrointestinal	**No**	**Yes**	**Unsure**
Acid Reflux	☐	☐	☐
Chron's Disease	☐	☐	☐
Genitourinary			
Pregnant	☐	☐	☐
Nursing	☐	☐	☐
Prostate disease	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Osteoporosis	☐	☐	☐
Muscle/Joint Pain	☐	☐	☐
Integumentary			
Shingles/Herpes Zoster	☐	☐	☐
Cold Sores/Herpes Simplex	☐	☐	☐
Rosacea	☐	☐	☐
Endocrine			
Type 1 Diabetes	☐	☐	☐
Type 2 Diabetes	☐	☐	☐
Thyroid Dysfunction	☐	☐	☐
Lymphatic/Hematologic			
High Cholesterol	☐	☐	☐
Anemia	☐	☐	☐
Allergic/Immunologic			
Seasonal Allergies	☐	☐	☐
Sjogren's Syndrome	☐	☐	☐
Lupus	☐	☐	☐

If you have a condition not listed, please explain and list any medications you are taking (include oral contraceptives, aspirin, over-the-counter medication, & home remedies):

_____

_____

_____

Do you have any allergies to medication? ☐ No ☐ Yes If yes, explain _____

_____

_____

Ocular History: Please check reason(s) for visit

	No	Yes	Unsure		No	Yes	Unsure
Loss of Vision	☐	☐	☐	Dryness	☐	☐	☐
Blurred Vision	☐	☐	☐	Mucous Discharge	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐	Redness	☐	☐	☐
Loss of Side Vision	☐	☐	☐	Sandy or Gritty Feeling	☐	☐	☐
Double Vision	☐	☐	☐	Itching	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐	Burning	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐	Foreign Body Sensation	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐	Excess Tearing/Watering	☐	☐	☐
Sties or Chalazion	☐	☐	☐	Glaucoma	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐	Cataract	☐	☐	☐
Retinal Disease	☐	☐	☐	Lazy Eye	☐	☐	☐
Eye Injury	☐	☐	☐	Crossed Eyes	☐	☐	☐

If you answered "Yes" to any of the above, or have a condition not listed, please explain and list medications/drops:

_____

_____

_____

Family History

Please note any family history (parents, grandparents, siblings, children…living or deceased) for the following conditions:

Medical Condition	No	Yes	Unsure	Relationship
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Heart Attack	☐	☐	☐	_____
Stroke	☐	☐	☐	_____

Ocular Condition	No	Yes	Unsure	Relationship
Cataract	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Amblyopia	☐	☐	☐	_____
Retinal Detachment	☐	☐	☐	_____

Social History – This information is kept strictly confidential.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes

If yes, please describe: _____

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

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

Does the patient have any learning or behavioral disabilities? Please explain: _____

_____

Glasses/Contact Lens History

Do you wear glasses? ☐ No ☐ Yes Are they for: ☐ Full time ☐ Reading ☐ Computer ☐ Driving

Do you wear contact lenses? ☐ No ☐ Yes Are they comfortable? ☐ No ☐ Yes

Type of contact lenses: ☐ Soft ☐ Rigid ☐ Extended Wear ☐ Other How often do you dispose of them? _____

Brand of contact lenses: _____ How many hours a day do you usually wear them? _____