

**NEW PATIENT QUESTIONNAIRE**

(Please complete this form to the best of your ability)

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Check one of the following  Ophthalmologist  Optometrist  Primary Care Physician

Other: \_\_\_\_\_

\*\* Please list (on the List of Physicians sheet) the names, mailing addresses, and phone numbers of any other physicians to whom you would like a report sent.

**MEDICAL HISTORY**

List any medical conditions, major illnesses, or injuries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all medication(s) you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any major surgeries you have had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any drug allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OCULAR HISTORY**

List any known eye conditions, surgeries, or injuries:

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List any ocular medication(s) you are currently using:

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**FAMILY HISTORY**

List any ocular or major medical problems in members of your family:

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**SOCIAL HISTORY AND LIFESTYLE**

Do you smoke?  Yes  Current every day smoker  Current some days  Heavy tobacco smoker  Light tobacco smoker

No:  Never Smoked  Former smoker: Quit; When?

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Do you drink alcohol?  Yes: How often?  No  Quit; When?

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Have you had a fall within the past year?  No  Yes; When?

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## REVIEW OF SYSTEMS

Do you currently have any problems in any of the following areas? If yes, please provide information.

<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<b>General Constitutional Symptoms</b> (e.g. fever, weight loss)
<input type="checkbox"/>	<input type="checkbox"/>	<b>Eyes</b> (e.g. loss of vision, distorted vision, dry eye, ocular pain) _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Ears / Nose / Mouth / Throat</b> (e.g. impaired hearing, sinus infection, hay fever) _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Cardiovascular</b> (e.g. heart attack, chest pain, hypertension, irregular heart beats) _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Respiratory</b> (e.g. wheezing, cough, shortness of breath) _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal</b> (e.g. nausea / vomiting, ulcer / bleeding, abdominal pain) _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary</b> (e.g. incontinence, bladder or sexually transmitted infections) _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Skin and / or Breast</b> (e.g. basal cell, squamous cell carcinoma, psoriasis) _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Neurologic</b> (e.g. stroke, migraine, headaches) _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Psychiatric</b> (e.g. mood disorders, anxiety, claustrophobia) _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Endocrine</b> (e.g. diabetes, thyroid disease) _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Musculoskeletal</b> (e.g. back injury or pain, arthritis) _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Hematologic</b> (e.g. anemia, past blood transfusions, leukemia, lymphoma) _____
<input type="checkbox"/>	<input type="checkbox"/>	<b>Allergic / Immunologic</b> (e.g. allergy to shellfish, iodine, contrast proparacaine or tetracaine) _____

## List of Physicians

Referring Physician: \_\_\_\_\_ Speciality: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zipcode

Internist : \_\_\_\_\_ Speciality: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zipcode

Optometrist : \_\_\_\_\_ Speciality: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zipcode

Additional Physician: \_\_\_\_\_ Speciality: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zipcode

Additional Physician: \_\_\_\_\_ Speciality: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zipcode

### Patient Information

Patient Name: \_\_\_\_\_  
First Name Last Name

Address: \_\_\_\_\_  
Street City State Zipcode

Birthdate: \_\_\_\_\_ Gender:  Male  Female  Other \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Marital Status: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Race: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

### Employment Information

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City State Zipcode

### Responsible Party Information

Responsible Party Name: \_\_\_\_\_  
First Name Last Name

Address: \_\_\_\_\_  
Street City State Zipcode

Birthdate: \_\_\_\_\_ Gender:  Male  Female Relationship: \_\_\_\_\_

Home  Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_  
First Name Last Name

Relationship: \_\_\_\_\_ Home or Mobile Phone: \_\_\_\_\_

Authorization: I hereby authorize the physician to furnish information to insurance carriers concerning this illness / accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_