New Patient Information Questionnaire

Name:_____ Today's date:_____

Date of Birth:_____ Gender: M___ F___ Marital Status: M___ S___

Street Address:_____ City:_____ Zip:_____

Parent or guardian (if under 18):_____

Home phone:_____ Cell:_____ Work:_____

Would you like to receive texts about future appointments or updates about contact/glasses orders? Yes_ No_

Email address:_____ Employer:_____

Last 4 SSN #: _____

When was your last eye exam?_____ Where?_____

Reason for todays exam?_____

Do you wear glasses currently? Yes__ No__ Have you ever? Yes__ No__

Do you wear contact lenses currently? Yes__ No___ Are you interested in contacts? Yes__ No__

Are you interested in learning if you are a candidate for lasik? Yes___ No___

List any family members who are currently patients here:_____

Who may we thank you for referring you to our office?_____

Vision Insurance

Insured's name:_____ Insured's last 4 SSN #: _____

Insurance Company:_____ Contract#: _____ Group#: _____

Insured's Date of birth:_____ Relationship to insured: _____

Medical Insurance

Insured's Name:_____ Insurance Company: _____

Member ID#: _____ Group#: _____

Insured's date of birth:_____ Relationship to insured:_____

Medical History

Please list any medications you take: Name of Medication | Condition | Dosage

_____

_____

_____

Do you have any allergies to any medications? If so please list, along with reaction:

_____

_____

_____

Primary Care Doctor's name? _____ Address? _____

Specialist Doctors?_____

OVER →

Please circle any of the following conditions you currently have or had a history of:

Cardiovascular: High Blood Pressure, Heart Disease, **Other**:_____

Constitutional: Blackouts, Dizziness, Fatigue, **Other**:_____

Endocrine: Cholesterol, Diabetes, Pituitary, Thyroid, **Other**:_____

Gastrointestinal: Ulcerative Colitis, Crohn's, **Other**:_____

Genitourinary: Prostate Disorder, Menopause, **Other**:_____

Hematologic/Lymphatic: Hodgkin's, Leukemia, Sickle Cell, **Other**:_____

Immunological: Lyme, Sarcoid, Herpes, **Other**:_____

Integumentary: Acne, Rosacea, **Other**:_____

Musculoskeletal: Arthritis, **Other**:_____

Neurological: Headache, Migraine, Bell's Palsy, Parkinson's, **Other**:_____

Psychiatric: ADD/ADHD, Autism, Alzheimer's, Dementia, Depression,Anxiety, **Other**:_____

Cancer:_____

Other: _____

Ocular history

Do you have a personal history of any of these concerns? Check if they apply:

Glaucoma___ Cataracts___ Macular Degeneration___ Conjunctivitis/Pink eye___

Allergies___ Dry Eye___ Eye Patch or Exercises___ Color Blindness____

Other: _____

Eye Surgery:_____Date:_____

Eye Injury:_____ Date:_____

Social History

Do you smoke or chew tobacco? Yes____ No____ Former user? Yes____ No____

Do you Drink Alcohol? Yes___ No___ Socially? Yes___ No___ Former user? Yes___ No___

Family History

Hypertension(high blood pressure) Yes___ No___ Relation:_____

Macular Degeneration Yes___ No___ Relation_____

Retinal Detachment Yes___ No___ Relation: _____

Glaucoma: Yes___ No___ Relation:_____

Diabetes: Yes___ No___ Relation:_____

Other:_____

Patient (or Guardian) Signature:_____ **Date: ____**_____