Eye-Site

New Patient Information

Full Name: _____

Date of Birth: _____ Age: _____

Preferred telephone: _____ Email Address:_____

Address: _____

Occupation: _____ Employer: _____

Emergency Contact:

Name: _____ Relationship: _____

Date of your last eye exam: _____

How did you hear about our office? _____

Your reason for today's visit: _____

Do you wear contact lenses? _____ YES _____ NO
If yes, what brand? _____

Are you having any specific concerns about your eye health / vision? If yes, please answer the following questions.

What symptoms are you experiencing? _____

Is it affecting the right eye, the left eye or both eyes? _____

When did it start? _____

Is the symptom intermittent or constant? _____

Is the condition the same over time or is it worsening? _____

How often do you feel this occurring? _____

Are you noticing any other associated symptoms? _____

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Ocular History

Please check if you have *ever* been diagnosed with any of the following conditions:

___ Age related macular degeneration
___ Glaucoma
___ Retinal holes/tears/detachments
___ Diabetic retinopathy
___ Amblyopia (lazy eye or an eye turning in/out)
___ Uveitis
___ Retinal dystrophy
___ Keratoconus

Family hx: List any relatives that have been diagnosed with one of these conditions?

_____

Medical History

Please check yes if you currently have or have been *ever* been diagnosed with any of the following conditions:

___ Diabetes (Type 1 or Type 2) IF yes, for how long? Last A1C or blood sugar?
___ Hypertension
___ Heart disease
___ Thyroid dysfunction
___ High cholesterol
___ History of stroke
___ HIV/AIDS

Are you currently pregnant or breastfeeding? _____ YES _____ NO

Additional medical conditions:

_____

***Current medications*:**

_____

_____

Allergies Please list any allergies to medications or environment below:

_____

_____

Do you use tobacco? _____ Frequency _____
Do you drink alcohol? _____ Frequency _____

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Review of Systems

Are you experiencing any of the following symptoms? If yes, please check all that apply. If you are experiencing something not listed, please explain this in the designated "other" area.

Constitutional

__unintentional weight loss __fatigue __fever __chills __Other:

Eyes

__double vision __flashes/floaters __eye pain __blurred vision __Other:

Ear, Nose, Throat

__ringing in ears __vertigo __sore throat __difficulty hearing __Other:

Cardiovascular

__chest pain __palpitations __fainting spells __Other:

Endocrine

__Heat/cold intolerance __loss of hair __Other:

Respiratory

__cough __wheezing __shortness of breath __Other:

Gastrointestinal

__nausea __vomiting __diarrhea __constipation __Other:

Genitourinary

__burning/pain with urination __ increased frequency of urination __Other:

Allergic/Immunologic

__ hives __eczema __hay fever __Other:

Psychiatric

__mood changes __anxiety __depression __insomnia __Other:

Hematological/Lymphatic

__swollen or tender lymph nodes __bruising easily __Other:

Musculoskeletal

__ joint pain or swelling __ muscle aches __ back pain __ stiffness __ Other:

Neurological

__migraines __new/unusual headaches __numbness/tingling __memory issues __balance issues __weakness in arms or legs __Other:

If you are not experiencing any symptoms at this time please check below:

___ I am experiencing no symptoms