



New Patient Questionnaire

Name: _____ Birth Date: _____

Current or Previous Occupation: _____

Contact Person: _____ Phone of Contact Person: _____

Family Doctor or Internist: _____ Doctor's Phone: _____

Doctor's Address: _____

What is the main ocular reason for your visit today? Please describe the problem:

Severity: 1 2 3 4 5
(Mild) (Moderate) (Severe)

Timing: Sudden Gradual

Duration: _____ Hours _____ Days
_____ Weeks _____ Months

Associated signs and symptoms: _____

Please Answer Every Question Yes or No - Thank You!

Have you ever had any of the following eye problems?

Yes	No		When
<input type="checkbox"/>	<input type="checkbox"/>	Cataract Surgery	
<input type="checkbox"/>	<input type="checkbox"/>	Other Eye Surgery	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	
<input type="checkbox"/>	<input type="checkbox"/>	Loss, Distorted, or Fluctuating Vision	
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	
<input type="checkbox"/>	<input type="checkbox"/>	Flashes of Light	
<input type="checkbox"/>	<input type="checkbox"/>	Floaters	
<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury	
<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	
<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain or Soreness	
<input type="checkbox"/>	<input type="checkbox"/>	Glare/Light Sensitivity	
<input type="checkbox"/>	<input type="checkbox"/>	Scratchy or Sandy Feeling in Eyes	
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	
<input type="checkbox"/>	<input type="checkbox"/>	Laser Treatment	
<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)	

Review of Systems

Do you now have, or have you ever had, any of the following problems?

Yes	No	Please Elaborate (When, Type)	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	How long?
<input type="checkbox"/>	<input type="checkbox"/>	Problems with your Endocrine System (Pancreas, Thyroid)	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	How long?
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems (Heart Attack or Disease)	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a pacemaker or a defibrillator?	
<input type="checkbox"/>	<input type="checkbox"/>	Circulation Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Problems with your Blood or Excessive Bleeding	
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary/Breathing Problems (Lung Disease, Asthma, Emphysema)	
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer - What Kind	
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease (Hepatitis, Jaundice)	
<input type="checkbox"/>	<input type="checkbox"/>	Depression	
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Sinus Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Recent Fever or Weight Loss	
<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems, or Changes in Bowel Habits	
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Neurologic Problems (Numbness, Seizures, Paralysis)	
<input type="checkbox"/>	<input type="checkbox"/>	Muscle or Joint Problems (Arthritis, etc.)	
<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems (Rashes, Excessive Dryness)	
<input type="checkbox"/>	<input type="checkbox"/>	Problems with your Immune System	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS / HIV	

Allergies

Are you allergic to any medications?

 No Yes

If yes, please list:

Medications

Please list all medications you take, including eye drops:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Surgeries

Please list types of surgery and date(s) if known, other than eye surgery:

1.	5.
2.	6.
3.	7.
4.	8.

Family History

Do any of your family members have:

Yes	No	Relationship to Patient	
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	
<input type="checkbox"/>	<input type="checkbox"/>	Blindness	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	

Advanced Directives

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a living will or other legal documents pertaining to life support or quality of care if you become incapacitated due to illness or injury?

History Reviewed: _____

Date: _____

Physician's Signature