eye INSTITUTE℠
AT MEDICAL CENTER CLINIC

New Patient History Form

Name:_____ Date: _____

Primary Care Physician: _____

Referring Physician/Optometrist/Other: _____

Pharmacy Name: _____ Address/Cross Street: _____

Pediatric Patients Only:

Birth Weight: _____ lbs _____ oz If premature birth, how many weeks? _____

Problems during pregnancy / delivery? Yes or No

Was the child's birth more than two weeks early? Yes or No

Did the child spend any time in NICU? Yes or No If yes, length of stay? _____

Delivery Method: Vaginal or Cesarean

Reason for Visit:_____

Eye History:

1. Do you wear glasses/contact lenses? Yes_____ No_____
2. Do you have problems reading with glasses? Yes_____ No_____
3. Does your eye condition affect these activities? *Please circle if applicable:*

Driving	Reading	Watching TV	Night Vision
Computer Use	Other: _____		

4. List any eye or eyelid surgeries, diseases, or injuries:_____

_____

_____

_____

Personal Medical History: *Please circle if any are applicable*:

Asthma/COPD	Arthritis	Blood Transfusions	Cancer
Diabetes	Heart Disease	Hepatitis	High Blood Pressure
High Cholesterol	HIV / AIDS	Kidney Disease	Lung Disease
Migraines	MRSA	Stroke	Thyroid Disease
Tuberculosis	Other: _____		

Past Surgical History: *Please list and date all other surgeries, non-eye related.*

Defibrillator: **YES**___ Date: _____ **NO**___

Pace Maker: **YES**___ Date: _____ **NO**___

_____

_____

_____

Eye Medications: _____

_____

_____

Other Medications: *If you brought a list, please give to the clinic staff.*
Blood Thinners: **YES**___ Type/Name: _____ **NO**___

_____

_____

List Drug Allergies: None Known or _____

_____

_____

Allergic to LATEX: **YES**___ **NO**___
If yes, please list date of confirmed testing: _____

Family Medical History: *Please circle and list family relationship- blood relatives only.*
Glaucoma _____
Retinal Disease _____
Macular Degeneration_____
Other: _____

Social History: *Please circle the answer.*

Are you a smoker?	Current, Everyday	Former Smoker	Never
Do you drink alcohol?	Yes or No	If Yes, then: Daily	Occasionally Rarely
Marital Status?	Married	Single Divorced	Widowed
Occupation?	_____	or	Retired

Review of Recent Symptoms: *Please circle if you are currently experiencing any of the following:*

Constitutional:
Unusual Fatigue
Weight Change

Blood:
Easy Bruising
Prolonged Bleeding

Gastrointestinal:
Abdominal Pain
Hard to Swallow

Bones and Joints:
Swelling in Joints
Painful or Stiff Joints

Neurological:
Fainting Spells
Loss of Balance
Muscle Weakness
Numbness
Seizures

Ears, Nose, Mouth, & Throat:
Bleeding Gums
Hearing Loss
Hoarseness
Sore Throat

Mood:
Depression
Excessive Worry
Memory Change

Skin:
Rash or Hives
Changes in Skin or Moles

Heart:
Chest Discomfort
Racing or Fluttering
Shortness of Breath
Swollen Feet or Ankles

Lungs:
Cough
Wheezing
Difficulty Breathing
Coughing up Blood

Urinary:
Urinary Frequency
Pain or Burning
Penile Discharge
Blood in Urine