NEW PATIENT HISTORY

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Who is your referring physician/optometrist and/or family doctor?______________________________________

In a few words, describe your chief concern regarding your eyes;

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HISTORY (PLEASE CHECK/CIRCLE ANY THAT APPLY)

EYE

Loss or blurred vision ( ) Loss of side vision/Double vision ( ) Gritty, dry or tearing eyes ( )

Itching/burning/redness/discharge ( ) Lazy Eye (poor vision in one eye ( ) Cataracts ( )

Glare/Light sensitive or Halos ( ) Eye pain or soreness ( ) Strabismus (in/out turning eye ( )

Infection of eyelashes, lids or styes ( ) Glaucoma ( ) Macular Degeneration ( ) Floaters ( )

Flashing Lights ( ) Migraines ( ) Eye Surgeries/ Eye Laser / Eye Trauma ( )

Other ( ) ____

OTHER

Cardiovascular (heart/blood vessels) ( ) High Blood Pressure ( ) High Cholesterol ( )

Thyroid Condition ( ) Asthma/ Breathing/ Lung Condition ( ) Cancer ( ) Stroke ( )

Recent Surgeries (not eye related) ( ) Other ( ) __________________________

Diabetes ( ) How many years ( ) Insulin ( ) Pills ( ) Diet ( )

Allergies ____

Current Medications ______________________________________

FAMILY HISTORY

Glaucoma ( ) Macular Degeneration ( ) Other eye conditions ( ) ____________________