Name
Physician:
Referring MD

MR #
Date:

New Patient Information

Daytime phone	Evening phone	Age

Reason for visit:

❐ Routine examination , no specific problems

❑ Chief complaint: (briefly describe the main problem; your doctor will obtain additional details)

Do you need your glasses checked or replaced ? yes no

Primary care physician?

Name:

Address:

Phone

Other health care providers ? (you wish us to communicate with)

Name:	Name:
Address:	Address:
Phone	Phone

List major illnesses

(hypertension, diabetes, heart disease, cancer)

List major surgery or hospitalization

Surgical type	Year

Medications:

Drug	Dose (if known)

Allergies (medications):

Drug	Type of reaction (e.g. rash)

PLEASE FILL OUT BOTH SIDES

REVIEW OF SYMPTOMS AND FAMILY HISTORY

Please check off any applicable symptoms or problems; your physician will obtain additional details if necessary.
If you have no problems in a specific area please indicate by checking off the "none" box.

EYES (please check box) ❑ No eye or visual complaints

❑ Loss of vision	❑ Eye pain	❑ Droopy eyelid	❑ Cataracts
❑ Blurred vision	❑ Light sensitivity	❑ Dryness	❑ Macular degeneration
❑ Distorted vision	❑ Halos/Glare	❑ Discharge	❑ Diabetic eye disease
❑ Night vision loss	❑ Flashing lights	❑ Tearing	❑ Glaucoma
❑ Double vision	❑ Red eye(s)	❑ Crossed eyes	❑ Lazy eye (Amblyopia, strabismus)
❑ Near vision blur	❑ Floaters	❑ See spots	❑ Other (explain in space below)

		Briefly expain any checked box (if necessary).
❑ GENERAL Fever, Night sweats, Weight loss, fatigue	❑ None	
❑ EAR , NOSE, THROAT Sinus, otitis, hearing loss, ringing in the ears, vertigo, other	❑ None	
❑ CARDIOVASCULAR Heart attacks, cholesterol problems, shortness of breath, high blood pressure, heart murmer, chest pains, palpitations, rheumatic fever	❑ None	
❑ RESPIRATORY shortness of breath, asthma, wheezing, cough, pain with breathing, emphysema, other	❑ None	
❑ PSYCHIATRIC Anxiety, depression, insomnia, other	❑ None	
❑ GASTROINTESTINAL Colitis, ulcers, rectal bleeding, diarrhea, nausea, vomiting, other	❑ None	
❑ KIDNEY, BLADDER, GENITALS Blood in urine, frequent urination, painful urination, renal failure, dialysis, other	❑ None	
❑ MUSCLES, JOINTS, BONES Arthritis, joint pains, fractures, disc problems, other	❑ None	
❑ SKIN Skin cancer, rashes, itchiness, moles, other	❑ None	
❑ NEUROLOGICAL Numbness, tingling of arms or legs, weakness, vertigo, gait, balance, coordination, speech problems, loss of conciousness, blind spots in vision, headaches, migraine.	❑ None	
❑ HORMONAL/ENDOCRINE Abnormal menstrual cycle, diabetes, thyroid problems, pituitary problems	❑ None	
❑ BLOOD Bleeding problems, anemia, blood loss, transfusions in the past, other	❑ None	
❑ Other		

FAMILY HISTORY	Relationship	SOCIAL HISTORY		
Eye Problems		Marital Status (Married, Single)	[S]	[M]
Blindness		Do you smoke	[Yes]	[No]
Glaucoma		Packs per day ?		
Cancer		How many years have you smoked?		
Heart Disease/Heart Attack		Do you drink alcohol ?	[Yes]	[No]
Diabetes		How frequently do you drink?		
Stroke		Are you driving ?	[Yes]	[No]
Other disorders (list in the explanation box)		Occupation ?		

Reviewed and discussed with patient ______________________ M.D.