# NEW PATIENT HISTORY

Name:______________________________________ Date: _______________

## Current Symptoms: (please check all that apply)

| | | | | |
|---|---|---|---|---|
| ☐ Blurred Vision | ☐ Loss of Vision | ☐ Itching | ☐ Tired Eyes | ☐ Excess Tearing/Watering |
| ☐ Double Vision | ☐ Glare/Light Sensitivity | ☐ Scratchiness | ☐ Sandy/Gritty Feeling | ☐ Chronic Eye Infections |
| ☐ Difficulty Reading | ☐ Flashes/Floaters Eye | ☐ Foreign Body Sensation | ☐ Mucous Discharge | ☐ Diabetes |
| ☐ Poor Night Vision | ☐ Pain or Soreness | ☐ Burning | ☐ Redness | ☐ Sties/Chalazions |
| ☐ Fluctuating Visual Acuity | ☐ Headaches | ☐ Dryness | ☐ Halos Around Lights | |

☐ Other Symptoms:

## Review of Systems:

Is there a personal or family history of the following? (Please check all that apply):

| | Personal | Family | If checked, please describe |
|---|---|---|---|
| Eye Disease | ☐ | ☐ | |
| Heart Disease | ☐ | ☐ | |
| Lung Disease | ☐ | ☐ | |
| Gastrointestinal Disease | ☐ | ☐ | |
| Neurological Disease | ☐ | ☐ | |
| Blood Disorders | ☐ | ☐ | |
| Musculoskeletal Disorders | ☐ | ☐ | |
| Skin Disorders | ☐ | ☐ | |
| Ear/Nose/Throat/Mouth Problems | ☐ | ☐ | |
| Endocrinological Disorders (i.e. thyroid, diabetes) | ☐ | ☐ | |
| Allergies (i.e. seasonal, food, etc.) | ☐ | ☐ | |

Other:

**THERE IS NO FAMILY OR PERSONAL HISTORY OF THE ABOVE CONDITIONS** ☐

| | Yes | No | If yes, please list |
|---|---|---|---|
| Are you allergic to any medications? | ☐ | ☐ | |
| Have you ever had eye surgery? (i.e. LASIK) | ☐ | ☐ | |

**HABITS:** Smoking: ☐ Yes ☐ No How much/often? Alcohol: ☐ Yes ☐ No How much/often?

**MEDICATIONS:**

PAST MEDICAL HISTORY: