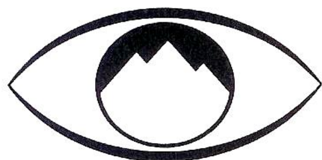
WE WILL NOT BILL YOUR INSURANCE UNLESS THIS FORM HAS BEEN COMPLETED



NEW PATIENT INFORMATION SHEET PAGE 2

PERSONAL HISTORY

1. Do you have any of the following eye diseases?

	Yes	No		Yes	No		Yes	No		Yes	No
Glaucoma	☐	☐	Retinal detachment	☐	☐	Diabetic retinopathy	☐	☐	Keratoconus	☐	☐
Cataracts	☐	☐	Macular degeneration	☐	☐	Eye injury	☐	☐	Other_______________		

2 Do you have diabetes? ☐ Yes ☐ No If YES, how long? ________________ Average blood sugar?______________

Most recent A1C ___________

3. Are you currently taking any medications? Yes ☐ No ☐ If YES, please list and include all dosage

____

____

____

____

4. Have you ever taken medication for prostate? ☐ Yes ☐No If YES, are you currently ? ☐Yes ☐ No

5. Do you have any drug or food allergies? Yes ☐ No ☐ If YES, please list: ______________________________

____

5. Have you previously had any of the following eye surgeries?

	Yes	No	If YES, which eye(s) /date of surgery		If YES		eye(s) /date
Cataract removal	☐	☐	________________	Retinal detachment	☐	☐	________________
Corneal transplant	☐	☐	________________	Vitrectomy	☐	☐	________________
Eye lid surgery	☐	☐	________________	Other_____________			
LASIK/PRK	☐	☐	________________				

6. Please list all past surgeries ☐ **No past surgeries**

____

____

____

FAMILY HISTORY

6. Does anyone in your family have any of the following:

	Yes	No		Yes	No		Yes	No
Glaucoma	☐	☐	Retinal detachment	☐	☐	Diabetes	☐	☐
Cataracts	☐	☐	Macular degeneration	☐	☐	High blood pressure	☐	☐
Strabismus	☐	☐	Heart disease	☐	☐			

SOCIAL HISTORY

7. Do you currently smoke? ☐ Yes ☐ No

8. Have you ever smoked in the past? ☐ Yes ☐ No

9. Do you use alcohol? ☐ Yes ☐ No If YES, average drinks per day (circle): < 1, 1-2, 3 or more

10. Do you use recreational drugs? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Do you have any of the following:

Eyes	Yes	No	Cardiovascular	Yes	No	Musculoskeletal	Yes	No
Poor vision	☐	☐	Chest pain	☐	☐	Muscle aches/stiffness	☐	☐
Eye pain	☐	☐	Irregular beat	☐	☐	Arthritis	☐	☐
Tearing	☐	☐	High blood pressure	☐	☐	Swollen joints	☐	☐
Redness	☐	☐						
Loss of vision	☐	☐						

Endocrine/Allergic	Yes	No	Respiratory	Yes	No	Neurological	Yes	No
Diabetes	☐	☐	Asthma	☐	☐	Numbness	☐	☐
Allergies	☐	☐	Shortness of breath	☐	☐	Weakness	☐	☐
Hay fever	☐	☐	Wheezing	☐	☐	Headaches	☐	☐
			Coughing	☐	☐	Paralysis	☐	☐
			Congestion	☐	☐			

Constitutional	Yes	No	Gastrointestinal	Yes	No	Psychiatric	Yes	No
Fever	☐	☐	Heartburn	☐	☐	Depression	☐	☐
Weight gain	☐	☐	Abdominal pain	☐	☐	Anxiety	☐	☐
Weight loss	☐	☐	Diarrhea	☐	☐			
Fatigue	☐	☐	Vomiting	☐	☐	Skin	Yes	No
			Pain or discomfort	☐	☐	Rashes	☐	☐
ENT/Mouth	Yes	No	Blood in urine	☐	☐	Excessive dryness	☐	☐
Hearing loss	☐	☐						
Sinus problems	☐	☐						
Sore Throat	☐	☐						

*** Patient Signature**________________________________ **Date**__________________________

Office use only

Reviewed by: __________________________ Reviewed by:__________________________

Reviewed by:__________________________ Reviewed by: __________________________