CENTER FOR
ADVANCED EYE CARE

# NEW PATIENT HISTORY FORM

| | | | |
|---|---|---|---|
| Date | Social security number | | Account number |
| First name | Last name | | Date of birth |
| Address | City | State | ZIP |
| Sex | Marital status | Race | Ethnicity |
| Email address | Home phone | | Cell phone |

## EMERGENCY CONTACT

| | | |
|---|---|---|
| Name | Phone | Relationship |

## PRIMARY CARE PHYSICIAN

| | |
|---|---|
| Name | Phone |

## REFERRED BY

| | |
|---|---|
| Name | Phone |

## PHARMACY

| | | | |
|---|---|---|---|
| Name | Phone | | |
| Address | City | State | ZIP |

Date of last eye exam

Do you wear ○ Glasses ○ Contacts

Reason for today's visit (symptoms)

**List any significant eye conditions and surgeries with dates**
(cataracts, macular degeneration, diabetic retinopathy, glaucoma, injuries to the eye, lasers, injections, lazy eye, crossed eyes, etc)

## MEDICAL HISTORY - Have you ever had any problems in the following areas?

| | | | | | |
|---|---|---|---|---|---|
| Diabetes | ○ Yes ○ No | Hepatitis | ○ Yes ○ No | Anemia | ○ Yes ○ No |
| Degenerative arthritis | ○ Yes ○ No | Hiatal Hernia | ○ Yes ○ No | Leukemia | ○ Yes ○ No |
| Rheumatoid arthritis | ○ Yes ○ No | Ulcers | ○ Yes ○ No | Sickle cell disease | ○ Yes ○ No |
| Alzheimer's Disease | ○ Yes ○ No | Skin Disease | ○ Yes ○ No | Thyroid problems | ○ Yes ○ No |
| Migraines | ○ Yes ○ No | Kidney Disease | ○ Yes ○ No | Emphysema | ○ Yes ○ No |
| Convulsions/seizures | ○ Yes ○ No | Pregnant | ○ Yes ○ No | Tuberculosis | ○ Yes ○ No |
| Stroke/paralysis | ○ Yes ○ No | Congestive Heart Failure | ○ Yes ○ No | Sarcoidosis | ○ Yes ○ No |
| Parkinson's Disease | ○ Yes ○ No | Heart Murmur | ○ Yes ○ No | Immune Problems | ○ Yes ○ No |
| Multiple Sclerosis | ○ Yes ○ No | Heart Attack | ○ Yes ○ No | High cholesterol | ○ Yes ○ No |
| Schizophrenia | ○ Yes ○ No | Irregular/fast heartbeat | ○ Yes ○ No | Cancer | ○ Yes ○ No |
| Lupus | ○ Yes ○ No | High blood pressure | ○ Yes ○ No | Please specify: | |

List any surgeries with dates

| Patient name | Date of birth |
|---|---|

Do you smoke or use tobacco? ☐ Never smoked/used tobacco ☐ Former smoker ☐ Unknown ☐ Current daily smoker ☐ Current heavy smoker ☐ Current casual smoker

Have you fallen in the last year? ◯ Yes ◯ No

If yes, how many falls in the last year? _____ Did the fall result in an injury? ◯ Yes ◯ No

**REVIEW OF SYSTEMS -** Do you presently have any problems in the following area? (Please select Yes or No)

| | | | |
|---|---|---|---|
| **CONSTITUTIONAL SYMPTOMS** | | **CARDIOVASCULAR** | |
| Fatigue | ◯ Yes ◯ No | Chest pressure/discomfort | ◯ Yes ◯ No |
| Fever | ◯ Yes ◯ No | Irregular Hearbeat/palpitations | ◯ Yes ◯ No |
| Night Sweats | ◯ Yes ◯ No | Other | |
| Other | | **GENITOURINARY (GENITALS/KIDNEY/BLADDER)** | |
| **HEAD, EARS, NOSE, AND THROAT** | | Dysuria (painful urination) | ◯ Yes ◯ No |
| Hearing Loss | ◯ Yes ◯ No | Hematuria (blood in urine) | ◯ Yes ◯ No |
| Other | | Other | |
| **RESPIRATORY (LUNGS/BREATHING)** | | **NEUROLOGICAL** | |
| Cough | ◯ Yes ◯ No | Dizziness | ◯ Yes ◯ No |
| Wheezing | ◯ Yes ◯ No | Headaches | ◯ Yes ◯ No |
| Other | | Other | |
| **GASTROINTESTINAL (STOMACH/INTESTINES)** | | **METABOLIC/ENDROCRINE** | |
| Constipation | ◯ Yes ◯ No | Cold Intolerance | ◯ Yes ◯ No |
| Diarrhea | ◯ Yes ◯ No | Heat Intolerance | ◯ Yes ◯ No |
| Vomiting | ◯ Yes ◯ No | Polydipsia (excessive thirst) | ◯ Yes ◯ No |
| Other | | Polyphagia (excessive hunger) | ◯ Yes ◯ No |
| **MUSCULOSKELETAL** | | Polyuria (frequent urination) | ◯ Yes ◯ No |
| Arthralgia (joint pain) | ◯ Yes ◯ No | Other | |
| Gait disturbance | ◯ Yes ◯ No | **PSYCHIATRIC** | |
| Joint swelling | ◯ Yes ◯ No | Emotional Changes | ◯ Yes ◯ No |
| Muscle weakness | ◯ Yes ◯ No | Other | |
| Other | | **ALLERGIC/IMMUNOLOGIC** | |
| **HEMATOLOGIC/LYMPHATIC** | | Environmental allergies | ◯ Yes ◯ No |
| Bleeding | ◯ Yes ◯ No | Food allergies | ◯ Yes ◯ No |
| Bruising | ◯ Yes ◯ No | Other | |
| Other | | | |
| **INTEGUMENTARY (SKIN)** | | | |
| Rash | ◯ Yes ◯ No | | |
| Other | | | |

COMMENTS:

| Patient name | Date of birth |
|---|---|

**FAMILY AND SOCIAL HISTORY:**

| Eye Diseases | Relationship to patient | Medical Diseases | Relationship to patient | Medical Diseases | Relationship to patient |
|---|---|---|---|---|---|
| ☐ Amblyopia (lazy eye) | | ☐ Arthritis | | ☐ Respiratory disease | |
| ☐ Blindness | | ☐ Asthma | | ☐ Stroke | |
| ☐ Cataracts | | ☐ Cancer | | ☐ Thyroid disease | |
| ☐ Corneal Disease | | ☐ Circulatory disorders | | ☐ Tuberculosis | |
| ☐ Glaucoma | | ☐ Diabetes | | ☐ Other | |
| ☐ Macular Degeneration | | ☐ Heart attack | | | |
| ☐ Retinal detachment | | ☐ Heart disease | | | |
| ☐ Retinal disorders | | ☐ High blood pressure | | | |
| ☐ Strabismus | | ☐ Kidney disease | | | |

**MEDICATIONS AND ALLERGIES:**
List all eye medications you take (prescription and over the counter). Attach a list if necessary.

| Name of Eye Medication | Dosage | Start Date |
|---|---|---|
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| | | |

List all other (non-eye) medications you take (prescription and over the counter).
Attach a list if necessary.

| Name of Medication | Dosage | Start Date |
|---|---|---|
| | | |
| | | |
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| | | |

List all known allergies.
☐ Check here if you have no known allergies

| Allergen | Reaction | Severity |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Patient name | Date of birth |
|---|---|

**INSURANCE INFORMATION**

| | |
|---|---|
| Primary Carrier: | |
| Identification Number: | |
| Group Number: | |
| Subscriber Name: | |
| Relationship to Subscriber: | ☐ Self ☐ Spouse ☐ Parent |
| Subscriber's Employer: | |
| Subscriber's Date of Birth: | |
| Social Security Number: | |

| | |
|---|---|
| Secondary Carrier: | |
| Identification Number: | |
| Group Number: | |
| Subscriber Name: | |
| Relationship to Subscriber: | ☐ Self ☐ Spouse ☐ Parent |
| Subscriber's Employer: | |
| Subscriber's Date of Birth: | |
| Social Security Number: | |

**Individual Responsible for Payment**

| | |
|---|---|
| Name: | |
| Address: | |
| Phone Number: | |
| Relationship to Patient: | |
| Date of Birth: | |

COMMENTS: