NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Preferred Phone: _____

Birthdate: _____/_____/_____ SSN: _____-_____-_____ Other Phone: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____ Gender (circle): Female Male

Guardian (if applicable) _____ Occupation_____

How did you hear about us? _____	If referred, who may we thank? _____
Circle appropriate selection: Minor Single	Married Divorced Widowed Separated
Race/Ethnicity: _____	Preferred Language: _____
Primary Care Physician/Office: _____	Date of last visit: _____

Please check appropriate answers and fill in blanks:

	No	Yes	Unsure
Constitutional			
Fever, Weight Loss/ Gain	☐	☐	☐
Cancer	☐	☐	☐

Ear, Nose, Mouth, Throat

Dry Throat/ Mouth	☐	☐	☐
Hearing Loss	☐	☐	☐
Sinusitis	☐	☐	☐
Neurological			
Seizures/ Epilepsy	☐	☐	☐
Tension Headaches	☐☐	☐	☐
		☐	☐

	No	Yes	Unsure
Gastrointestinal			
Acid Reflux	☐	☐	☐
Crohn's Disease	☐	☐	☐

Genitourinary

Pregnant	☐	☐	☐
Nursing	☐	☐	☐
Prostate Disease	☐	☐	☐
Bones/ Joints/ Muscles			
Shingles/ Herpes Zoster	☐	☐	☐
Cold Sores / Herpes Simplex	☐	☐	☐
		☐	☐
Muscle/ Joint Pain	☐	☐	☐
Integumentary			
Anxiety/ Depressio	☐	☐	☐

Migraines	☐	☐	☐
Tumor	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Psychiatric			
Anxiety/ Depression	☐	☐	☐
Other	☐	☐	☐

Vascular/Cardiovascular

Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Stroke	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Sleep Apnea	☐	☐	☐
Emphysema	☐	☐	☐
Chronic Bronchitis	☐	☐	☐

n			
Other	☐	☐	☐
Rosacea	☐	☐	☐

Endocrine Type 1 Diabetes	☐	☐	☐
Type 2 Diabetes	☐	☐	☐
Thyroid Dysfunction	☐	☐	☐
Lymphatic / Hematologic			
Asthma	☐	☐	☐
Sleep Apnea	☐	☐	☐
Allergic/ Immunologic	☐	☐	☐
Seasonal Allergies	☐	☐	☐
Sjorgren's Syndrome	☐	☐	☐
Lupus	☐	☐	☐

If you have a condition not listed, please explain, and list any medications you are taking (include oral contraceptives, aspirin, over-the-counter medication, & home remedies):

_____

_____

_____

Do you have any allergies to medication? ☐ No ☐ Yes If yes, explain

_____

_____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV/AIDS ☐ Syphilis

Ocular History: Please check reason(s) for visit

	No	Yes	Unsure		No	Yes	Unsure
Loss of Vision	☐	☐	☐	Dryness	☐	☐	☐
Blurred Vision	☐	☐	☐	Mucous Discharge	☐	☐	☐
Distorted Vision/ Halos	☐	☐	☐	Redness	☐	☐	☐
Loss of Side Vision	☐	☐	☐	Sandy or Gritty Feeling	☐	☐	☐

Double Vision	☐	☐	☐	Itching	☐	☐	☐
Glare/ Light Sensitivity	☐	☐	☐	Burning	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐	Foreign Body Sensation	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐	Excess Tearing/ Watering	☐	☐	☐
Sties or Chalazion	☐	☐	☐	Glaucoma	☐	☐	☐
Flashes/ Floaters in Vision	☐	☐	☐	Cataract	☐	☐	☐
Retinal Disease	☐	☐	☐	Lazy Eye	☐	☐	☐
Eye Injury	☐	☐	☐	Crossed Eyes	☐	☐	☐

If you answered “Yes” to any of the above, or have a condition not listed, please explain and list medications/drops:

_____

_____

_____

Family History

Please note any family history (parents, grandparents, siblings, children…living or deceased) for the following conditions:

Medical Condition	No	Yes	Unsure	Relationship
Cancer	☐	☐	☐	_____ _____ _
Diabetes	☐	☐	☐	_____ _____ _
High Blood Pressure	☐	☐	☐	_____ _____ _
Thyroid Disease	☐	☐	☐	_____ _____ _
Heart Attack	☐	☐	☐	_____ _____
Stroke	☐	☐	☐	_____ _____

Ocular Condition	No	Yes	Unsure	Relationship
Cataract	☐	☐	☐	_____ _____ _
Macular Degeneration	☐	☐	☐	_____ _____ _
Glaucoma	☐	☐	☐	_____ _____ _
Crossed Eyes	☐	☐	☐	_____ _____ _
Amblyopia	☐	☐	☐	_____ _____
Retinal Detachment	☐	☐	☐	_____ _____

Social History – This information is kept strictly confidential.

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes

If yes, please describe: _____

Do you drink alcohol?	☐ No	☐ Yes	If yes, type/amount/how long_____ _____
Do you use tobacco products?	☐ No	☐ Yes	If yes, type/amount/how long _____ _____
Do you use illegal drugs?	☐ No	☐ Yes	If yes, type/amount/how long _____ _____
Does the patient have any learning or behavioral disabilities? Please explain: _____			

Glasses/Contact Lens History

Do you wear glasses?	☐ No	☐ Yes	Are they for: ☐ Full time ☐ Reading ☐ Computer ☐ Driving
Do you wear contact lenses? ☐ No	☐ Yes		Are they comfortable? ☐ No ☐ Yes

Type of contact lenses:	□ Soft □ Rigid □ Extended Wear □ Other How often do you dispose of them? _____
Brand of contact lenses: _____	How many hours a day do you usually wear them? _____