

New Patient Medical History

Name _____ Date _____

How Is Your General Health?

- Excellent Fair
- Good Poor

Patient's Health History

(Please check yes or no)

- Allergies Yes No
- Asthma Yes No
- Auto-Immune Disease Yes No
- Blackouts Yes No
- Cancer Yes No
- Depression/Anxiety Yes No
- Diabetes Yes No
- Drug Sensitivity Yes No
- Hay Fever Yes No
- Headaches Yes No
- Head Trauma Yes No
- Heart Disease Yes No
- Hepatitis Yes No
- High Cholesterol Yes No
- High Blood Pressure Yes No
- HIV/Aids Yes No
- Lung Disease Yes No
- Migraine Headaches Yes No
- Muscle/Joint Pain Yes No
- Pregnant Yes No
- Skin Conditions Yes No
- Thyroid Condition Yes No
- Blindness/Reduced Vision Yes No
- Cataracts Yes No
- Glaucoma Yes No
- Poor Color Vision Yes No
- Retinal Disease/Detachment Yes No
- Turned Eye Yes No
- Use Tobacco Yes No
- Drink Alcohol Yes No
- Use Illegal Drugs Yes No
- Other _____

Are you taking any medications? Yes No
 Please List Meds: _____

Do you have any allergies to medications? Yes No
 Please List Meds: _____

Functional History

- Letters Blur As You Read Yes No
- Get Sleepy With Near-Centered Tasks Yes No
- Lose Your Place Often When Reading Yes No
- Pulling Sensation When Reading Yes No
- Eyestrain With Computer Use Yes No
- Avoid Certain Near Tasks Yes No

Eye Health History

Date of Last Eye Exam _____
 Name of Doctor _____
 Do you wear glasses? Yes No
 All the time Occasionally
 Reading Driving TV
 Do you wear contacts? Yes No
 Type _____ Hours/Day _____
 Describe any problems you have with your contacts _____

Have you had any serious eye disease, eye injury, or eye surgery? Yes No
 If yes, please explain: _____

Family Health History

(check those someone in your family has had)

- Allergies Yes No
- Asthma Yes No
- Cancer Yes No
- Diabetes Yes No
- Drug Sensitivity Yes No
- Hay Fever Yes No
- Heart Disease Yes No
- High Blood Pressure Yes No
- Migraine Headaches Yes No
- Skin conditions Yes No
- Thyroid Condition Yes No
- Blindness Yes No
- Cataracts Yes No
- Glaucoma Yes No
- Lazy Eye Yes No
- Poor Color Vision Yes No
- Retinal Disease Yes No
- Detachment Yes No
- Turned Eye Yes No
- Macular Degeneration Yes No
- Keratoconus Yes No
- Other _____

Contact Lens History

How often do you wear your lenses? _____
 How often do you replace your lenses? _____
 How often do you wear your lenses overnight? _____
 What solutions do you use? _____
 Is there anything you would like to see improved with your contact lenses? _____

Patient's Eye Health & Visual Symptoms

(N=Never S=Sometimes O=Often A=Always)

- Do your eyes ever feel or do you experience:
- Gritty or sandy sensations? N S O A
 - Pain or soreness? N S O A
 - Fluctuating vision? N S O A
 - Occasional tearing? N S O A
 - Swollen eye lids? N S O A
 - Blurred vision while reading? N S O A
 - Discomfort in windy conditions? N S O A
 - Discomfort in air conditioned areas? N S O A
 - Dryness? N S O A
 - Double vision? N S O A
 - Redness? N S O A
 - Mucous discharge? N S O A
 - Itching? N S O A
 - Burning? N S O A
 - Glare or light sensitivity? N S O A
 - Flashes or floaters? N S O A

Do you currently take any of the following medications? Antihistamines Hormones
 Antidepressants Diuretics Beta Blockers

Do you use artificial tears? Yes No
 If yes, how long does the relief last? _____
 Typically, how many artificial tear drops do you use per day? 2 3 4 or more
 Do you use eye drops for red or itchy eyes? Yes No
 Are you interested in Laser Vision Correction? Yes No
 Would you like to hear about CRT, a safe non-surgical alternative to LASIK? Yes No
 If you do not wear contact lenses, would you be interested in learning about the new, more convenient lens products now available? Yes No

Informed Consent for Dilated Exam

It is recommended that your pupils be dilated every 2 years or more often if necessary to rule out eye disease that may cause loss of sight or worse. Your pupils will be dilated for 2 to 4 hours, and your vision will be temporarily blurry, especially for near activities. Your eyes will be sensitive to sunlight, possibly making driving home and other activities somewhat difficult. If necessary, your dilation can be scheduled for a more convenient time.

Please check one and initial:

- I agree to be dilated today. _____
- I do not agree to be dilated but will schedule for another time. _____
- I refuse to have my eyes dilated because _____