eye INSTITUTE℠
AT MEDICAL CENTER CLINIC

New Patient History Form

Name:_____ Date: _____

Primary Care Physician: _____

Referring Physician/Optometrist/Other: _____

Pharmacy Name: _____ Address/Cross Street: _____

Reason for Visit:_____

Eye History:

1. Do you wear glasses/contact lenses? ☐ Yes ☐ No
2. Do you have problems reading with glasses? ☐ Yes ☐ No
3. Does your eye condition affect these activities? *Please mark if applicable:*

☐ Driving ☐ Reading ☐ Watching TV ☐ Night Vision
☐ Computer Use ☐ Other: _____

4. List any eye or eyelid surgeries, diseases, or injuries:_____

_____

_____

_____

Personal Medical History: *Please mark if any are applicable*:

☐ Asthma/COPD ☐ Arthritis ☐ Blood Transfusions ☐ Cancer
☐ Diabetes ☐ Heart Disease ☐ Hepatitis ☐ High Blood Pressure
☐ High Cholesterol ☐ HIV / AIDS ☐ Kidney Disease ☐ Lung Disease
☐ Migraines ☐ MRSA ☐ Stroke ☐ Thyroid Disease
☐ Tuberculosis ☐ Other: _____

Past Surgical History:

Please list and date all other surgeries, non-eye related.

Defibrillator: ☐ Yes Date:_____ ☐ No
Pace Maker: ☐ Yes Date:_____ ☐ No

_____

_____

_____

Eye Medications: *If you brought a list, please give to the clinic staff.*

_____ _____
_____ _____
_____ _____
_____ _____

Other Medications: *If you brought a list, please give to the clinic staff.*
Blood Thinners: ☐ Yes Type/Name: _____ ☐ No

_____ _____
_____ _____
_____ _____
_____ _____

List Drug Allergies: *If you brought a list, please give to the clinic staff.* ☐ None Known

_____ _____
_____ _____
_____ _____
_____ _____

Allergic to LATEX: ☐ Yes ☐ No
If yes, please list date of confirmed testing: _____

Family Medical History: *Please mark and list family relationship- blood relatives only.*
☐ Glaucoma _____
☐ Retinal Disease _____
☐ Macular Degeneration _____
☐ Other: _____

Social History: *Please mark the answer.*
Are you a smoker? ☐ Current, Everyday ☐ Former Smoker ☐ Never
Do you drink alcohol? ☐ Yes ☐ No If Yes, then: ☐ Daily ☐ Occasionally ☐ Rarely
Marital Status? ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Occupation? _____ or ☐ Retired

Review of Recent Symptoms: *Please list any pertinent bodily issues:* _____
_____
_____
_____