NEW PATIENT HISTORY

Name: ______________________________________ **Date:** __________________

Current Symptoms: (please check all that apply)

Blurred Vision	Loss of Vision	Itching	Tired Eyes	Excess Tearing/Watering
Double Vision	Glare/Light Sensitivity	Scratchiness	Sandy/Gritty Feeling	Chronic Eye Infections
Difficulty Reading	Flashes/Floaters	Foreign Body Sensation	Mucous Discharge	Diabetes
Poor Night Vision	Eye Pain or Soreness	Burning	Redness	Sties/Chalazions
Fluctuating Visual Acuity	Headaches	Dryness	Halos Around Lights	

Other Symptoms:

Review of Systems:

Is there a personal or family history of the following? (Please check all that apply):

	Personal	**Family**	**If checked, please describe**
Eye Disease			
Heart Disease			
Lung Disease			
Gastrointestinal Disease			
Neurological Disease			
Blood Disorders			
Musculoskeletal Disorders			
Skin Disorders			
Ear/Nose/Throat/Mouth Problems			
Endocrinological Disorders (i.e. thyroid, diabetes)			
Allergies (i.e. seasonal, drug, etc.)			
Other:			

THERE IS NO FAMILY OR PERSONAL HISTORY OF THE ABOVE CONDITIONS

HABITS: Smoking: Yes No
How much/often?

Alcohol: Yes No
How much/often?

MEDICATIONS:

PAST MEDICAL HISTORY: