New Patient History/Data Form

1. Name____ Date________________________

2. Do you have diseases or problems relating to:

☐ Heart ☐ Lungs ☐ Stomach/Intestines ☐ Joints ☐ Weight Loss
☐ Skin ☐ Blood Disease ☐ Kidney/Bladder ☐ Neurologic ☐ Psychiatric

3. Do you have:

☐ Diabetes ☐ High Blood Pressure ☐ Thyroid Disease ☐ Cancer ☐ Infectious Disease (HIV, Hepatitis C, etc.)

Please describe any problems in questions 2 & 3 that you have checked: _________________________________

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4. Are you pregnant: Yes ☐ No ☐

5. History of eye related problems:

☐ Contact Lens Wear ☐ Eye Trauma ☐ Lazy Eye ☐ Frequent cold sores

☐ Other Eye Diseases: ____

6. Have you had previous eye surgery or laser treatment? If so, what kind and when? ______________________

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7. Please list all *eye* medications you currently take: ____

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8. Please list all *other* medications you are taking *(dosage & frequency, if known)*: __________________________

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9. Do you have any allergies to medications? ____

10. Social history: Occupation:____

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do you smoke? If so, how much? ____

Hobbies: ____

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