NEW PATIENT QUESTIONNAIRE – Eyes on the Square

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 (if other than English): _____

Primary Care Physician: _____ Date of last eye exam (approximate): _____

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	☐	☐	☐
Glare/Light Sensitivity*	☐	☐	☐	Sandy or Gritty Feeling	☐	☐	☐
Double Vision	☐	☐	☐	Itching	☐	☐	☐
Loss of Side Vision	☐	☐	☐	Burning	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐	Foreign Body Sensation	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐	Tearing/Watering	☐	☐	☐
Styes or Chalazion	☐	☐	☐	Glaucoma	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐	Cataract	☐	☐	☐
Retinal Disease	☐	☐	☐	Lazy Eye	☐	☐	☐
Eye Injury	☐	☐	☐	Crossed Eyes	☐	☐	☐

* Not corrected with glasses or contact lenses

If you marked "Yes" to any of the above, have a condition not listed, or have had eye surgery, please explain:

_____

_____

_____

Family History

(parents, grandparents, siblings, children…living or deceased)

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

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

Social History – This information is kept strictly confidential.

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_____

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	☐	☐	☐
Migraines	☐	☐	☐
Tumor	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Psychiatric			
Anxiety	☐	☐	☐
Depression	☐	☐	☐
Other	☐	☐	☐
Vascular/Cardiovascular			
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Stroke	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Sleep Apnea	☐	☐	☐
Emphysema	☐	☐	☐
Chronic Bronchitis	☐	☐	☐

	No	Yes	Unsure
Gastrointestinal			
Acid Reflux	☐	☐	☐
Chron's Disease	☐	☐	☐
Genitourinary			
Pregnant	☐	☐	☐
Nursing	☐	☐	☐
Prostate disease	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Osteoporosis	☐	☐	☐
Muscle/Joint Pain	☐	☐	☐
Integumentary			
Shingles/Herpes Zoster	☐	☐	☐
Cold Sores/Herpes Simplex	☐	☐	☐
Rosacea	☐	☐	☐
Endocrine			
Type 1 Diabetes	☐	☐	☐
Type 2 Diabetes	☐	☐	☐
Thyroid Dysfunction	☐	☐	☐
Lymphatic/Hematologic			
High Cholesterol	☐	☐	☐
Anemia	☐	☐	☐
Allergic/Immunologic			
Seasonal Allergies	☐	☐	☐
Sjogren's Syndrome	☐	☐	☐
Lupus	☐	☐	☐

If you have a condition not listed, please explain: _____

_____

List all medications you are taking (include oral contraceptives, over-the-counter, & 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

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 (CLs)? ☐ No ☐ Yes. Are they comfortable? ☐ No ☐ Yes

Type of CLs: ☐ Soft ☐ Rigid ☐ Extended Wear ☐ Other How often do you dispose of them? _____

Brand of CLs: _____ How many hours a day do you usually wear them? _____