New Adult Ophthalmology Patient Questionnaire

If you are not adult, please request a pediatric patient questionnaire

Who is your primary care doctor?________________________________________________________

Which doctor referred you to our practice____________________________________________________

What problem are you having with your eyes?  ☐ Misaligned eyes  ☐ Double Vision  ☐ Other:________________________

Your Past Medical History (Check all that apply)

☐ Arthritis
☐ Asthma
☐ Allergies
☐ Bleeding problems
☐ Cancer
☐ List________________________
☐ Diabetes
☐ Type________________________
☐ Heart disease
☐ List________________________
☐ Gastrointestinal problems
☐ Kidney problems
☐ Lung problems
☐ List________________________
☐ Seizure disorder
☐ Skin problems
☐ List________________________
☐ Thyroid problems
☐ Urinary problems
☐ List________________________
☐ Stroke

Your Past Eye History (Check all that apply)

☐ Amblyopia (Lazy eye) R  L
☐ Cataracts  R  L
☐ Misaligned eyes
☐ Diabetic eye disease
☐ Droopy eye lid  R  L
☐ Glaucoma  R  L
☐ Glasses
☐ Injury to eye  R  L
☐ Retinal detachment R  L
☐ List________________________

Hospitalizations:
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

Surgeries:
________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

Family History (Check all that apply and list relationship)

☐ Asthma
☐ Bleeding problems
☐ Cancer
☐ List________________________
☐ Cholesterol problems
☐ Diabetes
☐ Heart disease
☐ High blood pressure
☐ Liver disease
☐ Lung disease
☐ Mental illness
☐ List________________________
☐ Muscular disorders
☐ Sickle cell disease
☐ Stroke
☐ Thyroid problems
☐ __________________________

Social History:

What kind of work do you do? __________________________ Marital status: __________________________
Are there any special social issues we should know about? _____________________________________________________

List Your Medication Allergies: _____________________________________________________________________________________________

List medications you are taking (Use back if need or provide your personal list for us to review):

<table>
<thead>
<tr>
<th>Name of Medicine</th>
<th>Dose</th>
<th>Frequency taken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Review of Systems: Are you experiencing problems with any of the following right now?

**Explanation of Symptoms**

**EARS, NOSE AND THROAT** ( ) Y ( ) N
Hearing loss, ear infections, chronic cough, etc. ____________________________

**CARDIOVASCULAR** ( ) Y ( ) N
Heart or blood vessel problems ____________________________

**RESPIRATORY** ( ) Y ( ) N
Asthma, breathing difficulties, etc. ____________________________

**GASTROINTESTINAL** ( ) Y ( ) N
Intestinal or digestive problems ____________________________

**UROLOGIC/GENITAL** ( ) Y ( ) N
Urinary infections, kidney disease ____________________________

**MUSCLES, BONES, JOINTS** ( ) Y ( ) N
Arthritis, orthopedic problems, etc. ____________________________

**SKIN** ( ) Y ( ) N
Acne, warts, molluscum, etc. ____________________________

**NEUROLOGICAL** ( ) Y ( ) N
Headaches, hydrocephalus, etc. ____________________________

**PSYCHIATRIC** ( ) Y ( ) N
Anxiety, depression, etc. ____________________________

**ENDOCRINE** ( ) Y ( ) N
Complications of Diabetes, thyroid disease, etc. ____________________________

**BLOOD, LYMPHATIC** ( ) Y ( ) N
Anemia, cholesterolemia, etc. ____________________________

**ALLERGIC/IMMUNOLOGIC** ( ) Y ( ) N
Hay fever, allergies, lupus, etc. ____________________________

**COMMENTS**

__________________________________________________________________________

__________________________________________________________________________

_________________________________  ________________________________
Patient Signature                  Date