NEW ADULT PATIENT INFORMATION

Name:_____

Telephone: Work ( )_____ ***Home ( )***_____ ***Cell ( )***_____

Age _____ ***Sex: M***_____ ***F***_____

Primary Physician:_____

Address, city/state_____

Any other doctor who should get a report:_____

Address, city/state_____

Briefly state the problem for which you are coming to the eye doctor _____

_____

_____

When did the problem first develop? _____

What treatment for this problem, other than surgery, have you received in the past? (for example prisms, patching, exercises)_____

_____

Have you had eye muscle surgery in the past? Yes_____ ***No***_____

If yes, approximate date(s)_____

Name of doctor(s) performing surgery _____

Address, city/state _____

List any other eye surgeries you have had (cataract, glaucoma, etc.):_____

_____

List any surgeries you have had (appendectomy, tonsillectomy, etc.): _____

_____

Present Medications (including eye medications_____

_____

Allergy to Medication _____

*Physician's Signature*_____ *Date* _____

Do you ***currently*** have an problems in the following areas? If **YES**, please provide information	**YES**	**NO**	**Details**
EYES (blur, glare, redness, pain, etc.)			
GENERAL/CONSTITUTIONAL (fever, weight loss, etc.)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc.)			
GENITAL,KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rashes, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, thyroid problems, etc.)			
BLOOD/LYMPH (anemia, cholesterolemia, etc)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY

DISEASE	**YES**	**NO**	**Relationship to Patient**
Blindness			
Glaucoma			
Amblyopia (lazy eye)			
Strabismus (misaligned eyes)			
Diabetes			
Heart disease/ High Blood pressure			
Cancer			
Kidney Disease			
Thyroid Disease			
Stroke			
Other (please specify)			

SOCIAL HISTORY

Current Occupation:_____

Education (high school, vocational school, college degree):_____

Marital status (single, married, divorced, widowed):_____

Do you drive? YES NO

Do you have difficulty with driving YES NO

Do you currently wear glasses YES NO If YES age of current Rx _____

Do you currently wear contact lenses YES NO If YES for how long _____

Have you ever tried to wear contact lenses YES NO

Have you ever had a blood transfusion YES NO

Do you drink alcohol? YES NO If YES how many drinks/day? _____

Do you smoke? YES NO If YES how many packs/day? _____

[Type text]

*Physician's Signature*_____ *Date* _____