

# NEW PATIENT HISTORY FORM

\_\_\_\_\_  
Patient Name (Please print.)

\_\_\_\_\_  
Guardian/Caretaker Name (Please print.)

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

## SYSTEMIC MEDICAL HISTORY or REVIEW OF SYSTEMS (ROS)

Please, check any **SYSTEMIC CONDITIONS** that you have currently or have had in the past.

### CARDIOVASCULAR SYSTEM

- Cardiovascular Disease (Heart Disease)
- Elevated Cholesterol**
- Hypertension (High Blood Pressure)**
- Myocardial Infarction (Heart Attack)
- Stroke
- Other, describe.

### CONSTITUTIONAL

- Dizziness
- Hunger excessive, Thirst excessive, or Urination excessive
- Sleep irregularity (including sleep apnea or insomnia)
- Weight gain (rapid) or Weight loss (rapid)
- Other, describe.

### ENDOCRINE SYSTEM

- Diabetes Mellitus**
- Diabetic Suspect**
- Renal Disease (Kidney Disease)
- Thyroid Disorder
- Other, describe.

### GASTROINTESTINAL SYSTEM

- Colon Cancer
- Inflammatory Bowel Disease
- Other, describe.

### GENITOURINARY SYSTEM

- Breast Cancer +
- Menopause
- Prostate Cancer or Prostate Disorder
- Sexually Transmitted Disease
- Other, describe.

### EAR/NOSE/MOUTH/THROAT

- Hearing Loss
- Sinusitis (chronic)
- Other, describe.

### HEMATOLOGIC/LYMPHATIC (BLOOD DISORDERS)

- Anemia
- Leukemia
- Other, describe.

### IMMUNOLOGIC SYSTEM

- Herpes Zoster (Shingles)
- HIV Positive
- Sarcoidosis
- Tuberculosis
- Other, describe.

### INTEGUMENTARY SYSTEM

- Acne Rosacea
- Lupus
- Skin Cancer +
- Other, describe.

### MUSCULOSKELETAL SYSTEM

- Ankylosing Spondylitis
- Arthritis (isolated joints)
- Arthritis Rheumatoid (systemic/multiple joints)
- Marfan's Syndrome
- Myasthenia Gravis
- Other, describe.

### NEUROLOGICAL SYSTEM

- Alzheimer's Disease +
- Bell's Palsy
- Brain Damage (trauma)
- Headache (chronic)
- Migraine Headache
- Multiple Sclerosis
- Other, describe.

### PSYCHIATRIC

- Psychiatric Disorder
- Other, describe.

### RESPIRATORY SYSTEM

- Asthma
- Lung Cancer
- Other, describe.

### OTHER

- Currently pregnant or breast-feeding
- Any other cancers, past or present, describe.
- Anything else not mentioned above, describe.

## SYSTEMIC SURGERY

Please, list any **SYSTEMIC SURGERIES** you have had:

- None

## OCULAR HISTORY

Please, check any **OCULAR CONDITIONS** that you have currently or have had in the past.

- None
- Age-Related Macular Degeneration
- Amblyopia (Lazy Eye)
- Cataract
- Diabetic Retinopathy
- Dry Eye Syndrome
- Eye Infection
- Eye Injury
- Glaucoma
- Keratoconus
- Retinal Detachment
- Strabismus (Turned Eyes)
- Other, describe.

## OCULAR SURGERY

Please, check any **OCULAR SURGERY** that you have had in the past.

- None
- Laser Vision Correction Surgery (Lasik or PRK)
- Cataract Surgery
- Other, describe.

## OCULAR MEDICATIONS

Please list any **OCULAR MEDICATIONS** you are taking.

- No ocular medications.

## SYSTEMIC MEDICATIONS

Please list any **SYSTEMIC MEDICATIONS** you are taking. (If you have a list of medications, our staff can photocopy it for you.)

- No systemic medications.

## ALLERGENS

Please list any **MEDICATIONS OR ANYTHING ELSE** to which you are allergic.

- No Medication Allergies (NKMA)
- No Seasonal/Food/Environmental Allergies
- Seasonal Allergies
- Other, describe.

## FAMILY OCULAR HISTORY

Please, check any **OCULAR CONDITIONS** that occur or have occurred in your family.

- None  Adopted, unknown
- Age-Related Macular Degeneration
- Amblyopia (Lazy Eye)
- Cataract
- Diabetic Retinopathy
- Glaucoma
- Keratoconus
- Retinal Detachment
- Strabismus (Turned Eyes)
- Other, describe.

## FAMILY SYSTEMIC HISTORY

Please, check any **SYSTEMIC CONDITIONS** that occur or have occurred in your family.

- None  Adopted, unknown
- Alzheimer's Disease
- Cardiovascular Disease (Heart Disease)
- Cancer
- Diabetes Mellitus
- Stroke
- Other, describe.

## SOCIAL HISTORY

Describe your **TOBACCO** use.

- Never smoked.
- Formerly smoked.
- Current smoker, everyday smoker.
- Currently smoker, some day smoker.

If you are a **FORMER SMOKER**, when did you quit?

- Within last year
- 1-2 years ago
- 3-4 years ago
- 4-5 years ago
- 5+ years ago
- 10+ years ago

Describe your **ALCOHOL** use.

- Never
- Social use only
- 1-2 drinks daily
- Alcohol dependency

Describe your **NARCOTIC DRUG** use, incl. **MARIJUANA**.

- Never
- Recreational use or Medical use
- Chemical dependence

Have you had any other **SOCIAL CHANGES** recently, such as death of a family member, divorce, etcetera?

- No.
- Yes, describe.