ADVANCED EYE CARE CENTER, P.A.

New Patient Questionnaire

DEMOGRAPHICS

Name **Last First MI**		**Today's Date**
Social Security #	**Date of Birth** **Month Day Year**	**Sex**
Address **Street City State Zip Code**		
Marital Status (circle one) Married Single Divorced Widowed		
Home Phone	**Work Phone**	
Cell Phone		
Occupation	**Employer**	
Emergency Contact **Relationship to Patient**	**Phone**	

REFERRAL

Whom may we thank for telling you about our practice? __Friend __ Family __Yellow Pages __ Insurance **Name __MD __Optometrist __Web Search**	
Primary Care Doctor **Name**	**Do you want us to send a report of today's exam to your doctor? ___ Yes ___ No**

EYE HISTORY

Do you wear glasses? No__ Yes__ If yes, for how long?_____

Do you wear contact lenses No__ Yes__ If yes, what type?_____

List all eye diseases/conditions that you have, and indicate how long you have had them.

Right eye condition	Month/Year	Left eye condition	Month/Year

EYE SURGERY

Have you had surgery on your eyes? No___ Yes___ If yes, please complete the following:

Right Eye Procedure	Month/Year	Left Eye Procedure	Month/Year

EYE MEDICATIONS

Medication	Eye(circle choice)	No. times per day	For how long
	Right Left Both		
	Right Left Both		
	Right Left Both		
	Right Left Both		
	Right Left Both		

MEDICAL HISTORY

Do you have a history of the following conditions? (please explain)

Diabetes_____**# of years**_____ **High blood Pressure**_____
Heart Disease_____ **Carotid Artery Disease**_____
Stroke_____ **Temporal Arteritis**_____
Ear Nose Throat Disease_____ **Respiratory Disease**_____
Urinary Problems _____ **Skin Problems** _____
Arthritis_____ **Neurologic Problems**_____
Psychiatric Problems_____ **Other** _____

Please list all previous surgical procedures/hospitalizations:

MEDICATIONS (please list names and dosages)

ALLERGIES (please list all drug and food allergies)

PERSONAL HISTORY

Do you smoke? Yes___ No ___ How much? **Drink alcohol Yes___ No__ How much?**

FAMILY HISTORY

Does anyone in your family have any eye diseases? No__ Yes__ If so, what is their relationship to you and type of eye disease do they have?

Relationship:_____ **Condition:**_____
Relationship:_____ **Condition:**_____
Relationship:_____ **Condition:**_____
Relationship:_____ **Condition:**_____

THANK YOU FOR YOUR HELP!