EYE INSTITUTE
OF SOUTHERN CALIFORNIA

NEW PATIENT HISTORY FORM

Patient Name: _____ **DOB:** _____

Date: _____ **Primary Care Doctor:** _____

Past Eye History:

Have you been diagnosed with any eye problems? Please mark all that apply.

☐Cataract ☐Dry eyes ☐Retinal Detachment
☐Glaucoma ☐Macular Degeneration ☐"Lazy eye" / amblyopia
☐Other_____

Have you had any eye injuries? If yes, please date and explain.

_____

Have you had any eye surgeries, including lasers? Please list types and dates.

_____

_____

Do you wear glasses? ☐ YES ☐ NO **Do you wear contact lenses?** ☐ YES ☐ NO

When was your last eye exam? _____ **When was your last dilated eye exam?** _____

Past Medical History:

Have you been diagnosed with any of the following? Please mark all that apply and explain.

☐Diabetes ☐Heart Attack ☐COPD/Emphysema/ Asthma ☐HIV
☐High Blood Pressure ☐Stroke ☐Depression
☐High Cholesterol ☐Liver Disease ☐Cancer
☐Heart Disease ☐Kidney Disease ☐Thyroid Disease
☐Other medical problems / history:

_____

_____

Past surgeries: Please list and date.

_____

_____

Allergies:

☐ NONE

Please list all medication allergies and reactions:

_____

Current Eye Medications (drops or ointments):

Name | Which eye? (Right, left, or both) | How often do you use it?

_____

_____

_____

Current Medications (including vitamins and over-the-counter medications):

Name, Dose, Times per day

_____ _____

_____ _____

_____ _____

Family History of Medical or Eye Problems (and relationship to you):

☐ Amblyopia ("Lazy eye") _____ ☐ Glaucoma _____

☐ Strabismus _____ ☐ Retinal Detachment _____

☐ Macular Degeneration _____ ☐ Cancer _____

☐ Family history of other medical problems:

_____

Social History:

Occupation:_____

Smoking: ☐ NO ☐ YES (How many packs/day? ____) ☐ Former Smoker (Quit date _____)

Alcohol Use: ☐ NO ☐ YES (How much _____) ☐ Occasional / Social

Other substance / drug use: _____

Review of Systems:

Do you currently have any of the following? If yes please explain:

Fever, chills, fatigue, weight loss, night sweats	☐ NO	☐ YES
Ear, Nose, Throat problems (difficult swallowing, decreased hearing, sinus problems)	☐ NO	☐ YES
Shortness of breath, cough, wheezing	☐ NO	☐ YES
Chest pain, heart palpitations, irregular heart beat	☐ NO	☐ YES
Stomach / Intestinal Problems (Pain, diarrhea, vomiting, bloody stools, heartburn)	☐ NO	☐ YES
Genito-urinary problems (blood in urine, burning with urination, discharge)	☐ NO	☐ YES
Easy bruising, abnormal bleeding	☐ NO	☐ YES
Neurologic Symptoms (headaches, dizziness, memory loss, numbness, weakness)	☐ NO	☐ YES
Cold or heat intolerance, excessive thirst, endocrine problems	☐ NO	☐ YES
Bone or joint problems	☐ NO	☐ YES
Skin changes, rashes, growths	☐ NO	☐ YES
Psychiatric problems (depression, anxiety)	☐ NO	☐ YES

_____

_____

_____ _____

Patient Signature | Physician Signature