CHITTICK

FAMILY EYE CARE

Exam Date: _____ / _____ / _____

Date of Birth: _____ / _____ / _____

Patient Name: _____

New Patient History Form

Welcome to **Chittick** Family Eye Care! We are pleased that you have chosen us as your primary eye care provider. Please fill out this form to the best of your ability. Our dedicated team is here to assist you with any questions.

Ocular History

Have you ever been diagnosed with any of the following conditions?

□ Cataract
□ Macular Degeneration
□ Glaucoma
□ Diabetic Retinopathy
□ Dry Eye
□ Eye Infection/ Allergy/Inflammation
□ Floaters and/or Flashes of Light
□ Iritis or Uveitis
□ Retina defects

Do you have any of the following eye concerns?

☐ Redness ☐ Burning ☐ Itching ☐ Tearing ☐ Discharge

Please list any additional concerns: _____

Do you have any of the following vision concerns?

☐ Blurred Vision
□ Eyestrain
□ Eye Pain
□ Severe Sensitivity to Light
□ Headache
□ Poor Night Vision
□ Night Glare
□ Double Vision
□ Total Loss of Vision

Please list any additional concerns: _____

GLASSES HISTORY

Are you planning to get new glasses today? ◯ Yes ◯ No
Do you currently wear glasses? ◯ Yes ◯ No
Do you wear sunglasses? ◯ Yes ◯ No
Are your sunglasses your most recent prescription? ◯ Yes ◯ No

CONTACT LENS HISTORY

Are you interested in trying contact lenses today? ◯ Yes ◯ No
Do you currently wear contact lenses? ◯ Yes ◯ No
If not currently wearing contact lenses, have you tried before? ◯ Yes ◯ No Why did you stop? _____

Medical History

Primary Care Physician: _____ Specialist: _____
Are you allergic to any medications: Yes No If yes, which ones: _____
List any major surgeries: _____

Do you Smoke? ◯Yes ◯No Do you drink alcohol? ◯Yes ◯No Do you drive ◯Yes ◯No
Are you pregnant or nursing? Yes No
If you have ever been exposed to HIV, Hepatitis, Tuberculosis, Chlamydia, or Gonorrhea please discuss with your doctor.

Current Medications including eye drops:

1. _____for _____ 6. _____ for _____
2. _____for _____ 7. _____ for _____
3. _____for _____ 8. _____ for _____
4. _____for _____ 9. _____ for _____
5. _____ for _____ 10._____ for _____

List any cancers and any treatment you may have received: _____

Review of Systems

Please mark beside any problem you currently have or have had in the following categories.

Constitutional
- □Developmental Disabilities
- □Cancer
- □Fatigue Syndrome

ENT
- □ Hearing Loss
- □ Sinusitis
- □ Dry Mouth
- □ Laryngitis

Neurological
- □ Multiple Sclerosis
- □ Epilepsy
- □ Cerebral Palsy
- □ Tumor
- □ Stroke/CVA
- □ Migraine

Psychological
- □ Depression
- □ Attention Deficit
- □ Anxiety Disorder
- □ Bipolar Disorder

Cardiovascular
- □ Hypertension
- □ Stroke/CVA
- □ Heart Disease
- □ Vascular Disease
- □ Congestive Heart Failure

Respiratory
- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ Chronic Obstruction
- □ Sleep Apnea

Gastrointestinal
- □ Crohn's
- □ Colitis
- □ Ulcer
- □ Acid Reflux
- □ Celiac Disease

Genitourinary
- □ Kidney Disease
- □ Prostate disease/cancer

Musculoskeletal
- □ Arthritis
- □ Osteoarthritis
- □ Fibromyalgia
- □ Muscular Dystrophy
- □ Ankylosing Spondylitis
- □ Osteoporosis
- □ Gout

Integumentary
- □ Eczema
- □ Rosacea
- □ Psoriasis
- □ Herpes Simplex/Cold Sores
- □ Herpes Zoster/Shingles

Endocrine
- □ Type 2 Diabetes Mellitus
- □ Type 1 Diabetes Mellitus
- □ Thyroid dysfunction
- □ Hormonal dysfunction

Hematologic/Lymphatic
- □ Anemia
- □ Large-volume blood loss
- □ Ulcer
- ☐ High Cholesterol

Allergic/Immune
- □ Drug Allergies
- □ Environmental Allergies
- □ Rheumatoid Arthritis
- □ Lupus
- □ Sjogren's Syndrome

Family History

Please list parents, grandparents, siblings, or children – living or deceased with the following conditions:

☐Glaucoma _____
☐Cataract _____
☐Lazy Eye_____
☐Macular Degeneration _____
☐Color Blindness _____
☐Retinal Detachment _____
☐Diabetes _____
☐Heart Disease _____
☐High Blood Pressure _____
☐Kidney Disease _____
☐Lupus _____
☐Thyroid Disease _____