Welcome to Greenspan Family Eyecare — New Patient Information &Questionnaire

Date: _____ **Date of Birth:**_____

Please circle: Mr. Mrs. Ms. Miss. Dr.

Last Name:_____ **Legal First Name:**_____ **M.I.**_____

Address:_____

City:_____ **State:**_____ **ZipCode:**_____

Home:_____ **Age:**_____ **Height:**_____ **Weight:**_____

Work:_____ **Sex(circle):** Male Female **BloodPressure:**_____

Cell:_____ **Email:**_____

Occupation:_____ **Social Security:**_____

Primary Care Physician:_____ **Date of Last Exam:**_____

Reason for Today's Visit:_____ **Referred By:**_____

Last Eye Exam

By Whom:_____

Y/N Do you currently wear glasses? **Circle:** Distance Reading Progressive

Y/N Do you wear contact lenses? **How often do you sleep or nap in your lenses?** _____

How often do you replace your lenses? _____ **Solution used:** _____

Lens Brand;_____ **Lens Powers: Right eye:**_____ **Left eye:**_____

Eye History

Do you currently, or have you ever had problems in any of the following areas?

Y/N	Blur at :Distance/Near/ Mid-range	Y/N	Cataract	Y/N	Double vision
Y/N	Eyestrain/ Tired eyes	Y/N	Glaucoma	Y/N	Macular Degeneration
Y/N	Crossed/ Lazy eye	Y/N	Retinal Detachment	Y/N	Flashes of light
Y/N	Floaters in vision	Y/N	Eye injury	Y/N	Eye surgery_____

Y/N Eye discomfort – circle all that apply

Redness Dryness Burning Itching Watery
Sore Sandy/Gritty Painful Light sensitive

General History

Y/N Are you currently taking medications? If so, please list all, including Over The Counter medications

Medications:	Condition Being Treated:
_____	_____
_____	_____
_____	_____
_____	_____

Y/N Allergies to medications?_____

Y/N Do you use tobacco products? If yes, what type, amount, how long? _____

Y/N Are you a former smoker? If yes, when did you quit?_____

Y/N WOMEN: Are you pregnant or nursing?

Review of Systems

Vascular/ Cardiovascular
- Y/N Diabetes
- Y/N High Blood Pressure
- Y/N Vascular disease
- Y/N Cholesterol

Endocrine
- Y/N Thyroid

Neurological
- Y/N Headaches
- Y/N Migraines
- Y/N Seizures

Psychiatric

Respiratory
- Y/N Asthma
- Y/N Chronic Bronchitis
- Y/N Emphysema

Bones/Joints/ Muscles
- Y/N Rheumatoid Arthritis
- Y/N Muscle pain

Ear/ Nose/ Throat
- Y/N Allergies
- Y/N Sinus problems
- Y/N Dry Mouth

Other

Family History

- Y/N High Blood Pressure
- Y/N Diabetes
- Y/N Heart Disease
- Y/N Cancer
- Y/N Thyroid
- Y/N Glaucoma
- Y/N Cataracts
- Y/N Macular Degeneration
- Y/N Retinal Disease
- Y/N Blindness

THERE IS A FEE FOR CONTACT LENS FITTING OR EVALUATION OF YOUR CURRENT CONTACT LENSES

Patient's Signature_____ **Date**_____