



THE RETINA CARE CENTER

NEW PATIENT QUESTIONNAIRE

Name: _____ Birth Date: _____

Current or Previous Occupation: _____

Contact Person: _____ Phone of Contact Person: _____

Family Doctor or Internist: _____ Doctor's Phone: _____

Doctor's Address: _____

What is the main ocular reason for your visit today? Please describe the problem:

Severity: 1 2 3 4 5
 (Mild) (Moderate) (Severe)

Timing: Sudden Gradual

Associated signs and symptoms:

Duration: _____ Hours _____ Days _____ Weeks _____ Months _____

Please Answer Every Question Yes or No – Thank You!

Have you ever had any of the following eye problems?

YES	NO		RIGHT/DATE	LEFT/DATE
<input type="checkbox"/>	<input type="checkbox"/>	Cataract Surgery		
<input type="checkbox"/>	<input type="checkbox"/>	Other Eye Surgery		
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma		
<input type="checkbox"/>	<input type="checkbox"/>	Loss, Distorted or Fluctuating Vision		
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision		
<input type="checkbox"/>	<input type="checkbox"/>	Flashes of Light		
<input type="checkbox"/>	<input type="checkbox"/>	Floaters		
<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury		
<input type="checkbox"/>	<input type="checkbox"/>	Double Vision		
<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain or Soreness		
<input type="checkbox"/>	<input type="checkbox"/>	Glare/Light Sensitivity		
<input type="checkbox"/>	<input type="checkbox"/>	Scratchy or Sandy Feeling in Eyes		
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration		
<input type="checkbox"/>	<input type="checkbox"/>	Retinal detachment		
<input type="checkbox"/>	<input type="checkbox"/>	Laser Treatment		
<input type="checkbox"/>	<input type="checkbox"/>	Other (Please Specify)		

Patient's Name: _____

REVIEW OF SYSTEMS

Do you now have, or have you ever had, any of the following problems?

Yes	No	Please Elaborate (When, Type)	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	How long?
<input type="checkbox"/>	<input type="checkbox"/>	Problems with Your Endocrine System (Pancreas, Thyroid)	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	How long?
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems (Heart Attack or Disease)	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a pacemaker or defibrillator?	
<input type="checkbox"/>	<input type="checkbox"/>	Circulation Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Problems with your Blood or Excessive Bleeding	
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary/Breathing Problems (Lung Disease, Asthma, Emphysema)	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer – What Kind?	
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease (Hepatitis, Jaundice)	
<input type="checkbox"/>	<input type="checkbox"/>	Depression	
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Sinus problems	
<input type="checkbox"/>	<input type="checkbox"/>	Recent Fever or Weight Loss	
<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems, or Changes to Bowel Habits	
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Neurologic Problems (Numbness, Seizures, Paralysis)	
<input type="checkbox"/>	<input type="checkbox"/>	Muscle or Joint Problems (Arthritis, etc.)	
<input type="checkbox"/>	<input type="checkbox"/>	Skin problems (Rashes, Excessive Dryness)	
<input type="checkbox"/>	<input type="checkbox"/>	Problems with your Immune System	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS / HIV	

CURRENT MEDICATIONS

Please list all medications you take, including eye drops:

Name	Dosage (mg)	How Often		Name	Dosage (mg)	How Often

Do you take aspirin (Excedrin, Anacin, etc.)? No Yes If yes, how much? _____

Patient Name _____

SURGICAL HISTORY

SURGERY	DATE	SURGEON		SURGERY	DATE	SURGEON

Have you ever had any ANESTHETIC COMPLICATIONS? No Yes If Yes, please explain:

ALLERGIES

Are you allergic to any medications? No Yes If yes, please list name and reaction (Use back of page if needed).

FAMILY HISTORY

Do any of your family members have :

Yes	No	Relationship to Patient	
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	
<input type="checkbox"/>	<input type="checkbox"/>	Blindness	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	

SOCIAL HISTORY

Occupation (prior to retirement, if retired) _____

Smoke? No Yes, How much? _____

Alcohol? No Yes, How much? _____

ADVANCED DIRECTIVES

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a living will or other legal documents pertaining to life support or quality of care if you become incapacitated due to illness or injury?

History Review: _____ Date: _____

Physician's Signature