JERVEY EYEGROUP
Our Mission: Your Best Vision

New Patient History Form

Date: _____

PATIENT'S NAME:	DOB:	AGE:	SEX:
PHONE NUMBER (CELL):	(HOME):		
E-MAIL ADDRESS:			
OCCUPATION:	EMPLOYER:		
PRIMARY CARE PHYSICIAN:			
ALLERGIES (drug and food):			

MEDICAL CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST. PLEASE CHECK YES OR NO (if yes, please explain in the blanks below or on the back)

	Yes	No	If yes, please explain
Chronic fever, unexpected weight loss or gain, fatigue			
Ear, nose or throat problems (hearing loss, sinusitis, sore throat)			
Heart problems (high blood pressure, heart attack, chest pain)			
Blood problems (anemia, high cholesterol)			
Lung problems (emphysema, asthma, short of breath, wheezing)			
GI problems (heartburn, abdominal pain, diarrhea, vomiting)			
Urinary problems (prostate, pain, blood in urine)			
Skin problems (eczema, rash, bruising, cancers)			
Musculoskeletal problems (arthritis, gout, muscle aches)			
Endocrine problems (diabetes, thyroid)			
Neurological problems (headaches, strokes, seizure, numbness)			
Psychiatric problems (depression, anxiety, bipolar)			
Allergies (seasonal, environmental)			
Other			

Do you smoke? _____ How much? _____

Do you drink alcohol? _____ How much? _____

PLEASE LIST ANY…

Medications: If you have a list, please have it ready so we can make a photo copy.

Prescription meds

Over the counter meds

Supplements

Any Past Surgeries? Please List

Any Past Hospitalizations? Please List

FAMILY HISTORY – DOES ANYONE IN THE FAMILY (blood relatives) HAVE EYE DISEASE OR SERIOUS MEDICAL PROBLEMS?

	Yes	No	If yes, please list family member
Droopy lid			
Glaucoma			
Retinal detachment			
Macular degeneration			
Eye surgery			
Diabetes			
Thyroid disease			
Other			

YOUR EYE HISTORY – HAVE YOU HAD ANY OF THE FOLLOWING?

	Yes	No	If yes, please explain
Any diseases of your eyes (cataracts, glaucoma, macular degeneration, lazy eye, retinal detachment)?			
Any past surgery to your eyes?			
Any past injury to your eyes?			
Any past serious infections of your eyes?			
Use any eye drops or other eye medications?			
Do you wear glasses? For distance, or near, or both?			
Do you wear contacts? For distance, or near, or both?			

How old are your glasses? _____

Approximately when was your last eye exam? _____

Are you having any problems with your vision? Any problems with the comfort of your eyes?

Please list and explain if so:

Vision Needs (reading, driving, computer, sewing, etc.):