Tennessee River Eye Clinic

New Patient History (Blank answers will be recorded as no/negative in your electronic record.)

Name: _____ **Date of birth:** _____

What eye problem prompted this appointment? _____

List all allergies: _____

Past Eye history:

Problems: _____

Prior Eye Surgery: _____

Current Eye Medicines, include which eye and how often:

_____

Past Medical history:

[ ] Diabetes [ ] Thyroid problems [ ] High blood pressure [ ] Stroke

[ ] COPD [ ] Cancer [ ] Arthritis [ ] Heart

[ ] Other problems: _____

_____

_____

Past Surgery:

_____

_____

_____

Current medications/supplements, include milligrams and how often:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Other:

Do you have any blood relatives with…

[ ] glaucoma _____ [ ] cataract _____

[ ] macular degeneration _____ [ ] other eye disease?_____

Continue on next page → → → → →

New Patient page 2

Smoking: [ ] _____ packs/day [ ] Ex-smoker [ ] Never smoked

Drinking: [ ] none [ ] 0-2 [ ] 2-10 [ ] over 10

Drug use: [ ] no [ ] yes. Explain_____

Do you now or have you ever had...

[ ] contact lenses, [ ] eye pain, [ ] double vision, [ ] glaucoma, [ ] macular degeneration, [ ] cataracts, [ ] dry eyes, or [ ] flashes/floaters? Explain: _____

_____

[ ] hearing loss, [ ] ringing in ears, or [ ] vertigo? Explain: _____

_____

[ ] chest pain, [ ] dizziness, [ ] fainting, [ ] shortness of breath, [ ] palpitations, or [ ] difficulty laying flat? Explain: _____

[ ] fatigue/weakness, [ ] fever, or [ ] weight gain/loss? Explain: _____

_____

[ ] cough, [ ] congestion, [ ] wheezing, or [ ] asthma? Explain: _____

_____

[ ] heartburn, [ ] nausea/vomiting, [ ] jaundice/hepatitis, or [ ] bloody stools? Explain: _____

_____

[ ] pain/difficult urination, [ ] bloody urine, [ ] kidney stones, or [ ] sexually transmitted disease? Explain: _____

[ ] anxiety/depression, [ ] mood swings, or [ ] difficulty sleeping? Explain: _____

_____

[ ] increased thirst, [ ] increased hunger, [ ] increased urination, [ ] abnormal sweating, or [ ] fingernail changes? Explain: _____

_____

[ ] bruising, [ ] bleeding gums, [ ] prolonged bleeding, [ ] heavy aspirin use? Explain: _____

_____

[ ] stiffness, [ ] arthritis, or [ ] joint pain/swelling? Explain: _____

_____

[ ] rashes/sores, [ ] skin lesions, or [ ] eczema? Explain: _____

_____

[ ] seizures, [ ] weakness/paralysis, [ ] numbness, or [ ] tremors? Explain: _____

_____

[ ] hives, [ ] itching, [ ] runny nose, or [ ] sinus pressure? Explain: _____

_____

My responses are accurate for use in my medical decisions.

Sign here: _____ Date: _____