Tennessee River Eye Clinic
Patient Information

New patient history (blank answers will be recorded as no/negative in your electronic record).

Name_____ Date of birth_____
Primary Care doctor_____ Eye Care doctor_____ List any other doctors that you see_____
What is your occupation _____

What eye problem prompted this appointment?_____
List allergies_____

Past *EYE* history:
Problems_____
Prior eye surgery_____
Current EYE medications, include which eye and how often_____

Past *MEDICA*L history:
[ ] Diabetes [ ] thyroid problems [ ] high blood pressure [ ] stroke [ ] COPD [ ] cancer [ ] arthritis [ ] heart other_____

Past *SURGERY* history:
_____
_____
_____

CURRENT MEDICATIONS/SUPPLEMENTS, INCLUDE MILLIGRAMS AND HOW OFTEN:
_____
_____
_____

Other:
Do you have any blood relatives with: [ ] glaucoma [ ] cataract [ ] macular degeneration [ ] other eye disease:_____

Smoking [ ] ____packs/day [ ] ex-smoker [ ] never smoked

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

Drug use: [ ] no [ ] yes, explain_____

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Do you now or have you ever had…
[ ] eye pain [ ] double vision [ ] glaucoma [ ] macular degeneration [ ] flashes/floaters [ ] dry eyes [ ] contact lenses
explain_____

[ ] hearing loss [ ] ringing in ears [ ] vertigo explain _____

[ ] chest pain dizziness [ ] fainting [ ] shortness of breath [ ] palpitations [ ] difficulty laying flat
explain_____

[ ] fatigue/weakness [ ] fever [ ] weight gain/loss
explain _____

[ ] cough [ ] congestion [ ] wheezing [ ] asthma
explain _____

[ ] heartburn [ ] nausea/vomiting [ ] jaundice/hepatitis [ ] bloody stools
Explain _____

[ ] pain/difficult urination [ ] bloody urine [ ] kidney stones [ ] sexually transmitted disease
Explain _____

[ ] anxiety/depression [ ] mood swings [ ] difficulty sleeping
Explain _____

[ ] increased thirst [ ] increased hunger [ ] increased urination [ ]abnormal sweating [ ] fingernail changes
Explain _____

[ ] bruising [ ] bleeding gums [ ] prolonged bleeding [ ] heavy aspirin use
Explain _____

[ ] Stiffness [ ] arthritis [ ] joint pain/swelling
explain _____

[ ] rashes/sores [ ] skin lesions [ ] eczema
explain _____

[ ] seizures [ ] weakness/paralysis [ ] numbness [ ] tremors
Explain_____

[ ] hives [ ] itching [ ] runny nose [ ] sinus pressure
explain _____

My responses are accurate for use in my medical decision.
Sign here _____ Date _____