Tennessee River Eye Clinic

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_____

Do you now or have you ever had…..(Continued on next page)