THE RETINA PARTNERS

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New Patient Questionnaire

Name:_____ Today's Date:_____
First M.I. Last

Age:_____ Gender:_____ Height:_____ Date of Birth:_____

Referring Physician:_____ Telephone #:_____

Primary Care Physician:_____ Telephone #:_____

Describe your present vision disorder or eye complaint:
Eye Drops and dosage: None
Previous Eye Surgeries and/or Lasers: None
General Medical History and Surgeries:
Please list all medications you currently use (include over the counter and herbal medications:

Family History	Yes	No	Relationship (Mother, Father, Sibling, Grandparent)
Blindness			
Diabetes			
High Blood Pressure			
Macular Degeneration			
Glaucoma			

Do you have any of the following problems?	Yes	No	If Yes, please describe:
1. **Allergies** to medication?			
2. **Constitutional** (fever, weight loss, other)			
3.**Ear/nose/mouth** (hearing loss, sinus problems, sore throat)			
4. **Respiratory** (asthma, shortness of breath, wheezing, coughing)			
5. **Gastrointestinal** (heartburn, abdominal pain, diarrhea, vomiting)			
6. **Genitourinary** (urinary problems, blood in the urine)			
7.**Integumentary** (skin rashes, excessive dryness)			
8. **Musculoskeletal** (muscle aches, joint pain, swollen joints)			
9. **Neurological** (numbness, weakness, headaches, paralysis)			
10. **Hematologic/lymphatic** (blood disorders, leukemia)			
11. **Allergic/Immunologic** (hay fever, allergies)			
12. **Endocrine** (diabetes, thyroid problems) If diabetic, duration?			
13. **Cardiovascular** (heart problems , chest pain, heart rate, sore throat)			
14. **Psychiatric** (depression, anxiety)			

SOCIAL HISTORY				
Occupation:				
Do you or have you ever smoked?	Yes	No	If Yes:___Packs for _____Years	Years Quit:_____
Do you drink alcohol	Yes	No	If Yes: How much? Occasional 1/day 2-3 day 4+/day	

Comments:_____

Completed by:_____ Date: _____

Reviewed by:_____ Date: _____