Date_____

MRN_____

# Dayton Eye Associates

New Patient Questionnaire

Patient's Name: _____ Date of Birth:_____

Please check "yes or "no" for each of the following questions:

**Family History:** Have any of the patient's relatives had any of the following?

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Blindness<br>If Yes, who?_____ | ☐ | ☐ | Cataracts before age 50<br>If Yes, who?_____ |
| ☐ | ☐ | Macular degeneration<br>If Yes, who?_____ | ☐ | ☐ | Glaucoma<br>If Yes, who?_____ |
| ☐ | ☐ | Other serious eye disease<br>If Yes, who?_____ | ☐ | ☐ | Serious Medical Condition<br>(e.g. diabetes, high blood pressure, heart disease, cancer)<br>If Yes, please explain:_____ |

**History of Eye Problems:**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Eye injury<br>Details:_____ | ☐ | ☐ | Eye surgery<br>Details:_____ |
| ☐ | ☐ | Glaucoma | ☐ | ☐ | Macular degeneration |
| ☐ | ☐ | Other eye problems: _____ | | | |

**Recent Symptoms**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Crossed or wandering eye | ☐ | ☐ | Headaches |
| ☐ | ☐ | Excessive squinting | ☐ | ☐ | Tired eyes when reading |
| ☐ | ☐ | Double vision | ☐ | ☐ | Excessive eye rubbing |
| ☐ | ☐ | Frequent tearing or discharge | ☐ | ☐ | Blurred vision |
| ☐ | ☐ | Light sensitivity | | | |

**Other vision or eye symptoms not mentioned above:**

**Other Medical Problems**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | Fever | ☐ | ☐ | Headaches |
| ☐ | ☐ | Fatigue | ☐ | ☐ | Weight loss/gain |
| ☐ | ☐ | Skin rash | ☐ | ☐ | Joint pain or swelling |
| ☐ | ☐ | Hearing loss/deafness | ☐ | ☐ | Nausea/vomiting |
| ☐ | ☐ | Asthma | ☐ | ☐ | Breathing difficulties |
| ☐ | ☐ | Heart rhythm problems | ☐ | ☐ | Chest pain |
| ☐ | ☐ | Numbness | ☐ | ☐ | Weakness |
| ☐ | ☐ | Depression | ☐ | ☐ | Anxiety |

List all previous surgery, hospitalizations, major illnesses, or injuries (other than eye problems):

List all medications the patient is taking, including eye drops:

List all medication allergies:

Do you smoke? If yes, how much:_____ Drink alcohol? If yes, how much:_____

If employed, how many hours per week do you work?_____

M.D. Signature:_____ Date:_____