EMORY
HEALTHCARE

Patient Label area

**Emory Eye Center –New Patient Questionnaire**

**Patient Name: _____ Date: _____**

**Current Address: _____**

**Current Phone: _____ Date of Birth: _____**

**Primary Care Physician: _____ Referring Physician: _____**

(First & Last Name) (First & Last Name)

Pharmacy Name: _____ Phone #: (_____) _____

**Please answer all questions to the best of your ability and return the completed questionnaire to the technician or technologist when you are called.**

**Reason for Exam** (please explain): _____

_____

General Health (please check): Excellent Good Fair Poor

| Past Medical History | Yes | No | Year of Diagnosis | Details |
|---|---|---|---|---|
| Arthritis | | | | |
| Asthma | | | | |
| Cancer (please specify) | | | | |
| Diabetes | | | | |
| Heart Disease | | | | |
| Hypertension | | | | |
| Kidney Disease | | | | |
| Skin Disease | | | | |
| Stroke | | | | |
| Neurologic Disorder | | | | |
| Other | | | | |

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**CURRENT MEDICATIONS**

Please list all medications you are currently taking, or check:

 No current medications

| Medication Name | Amount Per Day | Reason |
|---|---|---|
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**ALLERGIES**

Please list all medications or substances to which you are allergic and specify the type of reaction, or check:

 **No known allergies**

| **Allergies** | **Reaction** |
|---|---|
| | |
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| | |

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**SURGERY OR HOSPITALIZATION**

| Surgery/ Hospitalization | Year | Details |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**OCULAR HISTORY**

History of Eye Infection, Injury, or Surgery? No Yes

Describe briefly: _____

_____

If the patient is a child, you must complete this section. If the patient is an adult, you may skip this section.

Parent's Name: _____ Occupation: _____

Parent's Name: _____ Occupation: _____

With whom does the patient live? _____

Who is your child's pediatrician? Name: _____

Address: _____ Phone: _____

Were there any problems with your child's gestation (pregnancy), delivery, or during the first 3 months of life?

No Yes If yes, please describe: _____

_____

_____

Has your child's growth and development been normal? Yes No If no, please describe: _____

_____

_____

**SOCIAL HISTORY**

Smoke: Former smoker Never smoker Yes If yes, at what frequency?_____

Alcohol: None Yes If yes, at what frequency?_____

Drugs: None Yes If yes, please describe: _____

Driving: Drives in the Daytime Drives at Night

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**FAMILY HISTORY**

| Family History of Illness/Disease | Details | Relationship |
|---|---|---|
| Ocular Disease | | |
| Diabetes | | |
| Heart Disease | | |
| Hypertension | | |
| Other (please explain) | | |

**REVIEW OF SYSTEMS**

Please indicate yes or no as deemed appropriate regarding the following symptoms.
If you are not sure, please leave blank

| NO | YES | **Eyes** | **Comment** |
|---|---|---|---|
| ☐ | ☐ | Blurred vision | _____ |
| ☐ | ☐ | Change in vision | _____ |
| ☐ | ☐ | Eye pain | _____ |

| NO | YES | **Constitutional/Symptoms** | **Comment** |
|---|---|---|---|
| ☐ | ☐ | Change in weight | _____ |
| ☐ | ☐ | Change in activity level | _____ |
| ☐ | ☐ | Change in general health | _____ |

| NO | YES | **Ear, Nose, Throat & Mouth** | **Comment** |
|---|---|---|---|
| ☐ | ☐ | Hearing problem | _____ |
| ☐ | ☐ | Throat soreness | _____ |
| ☐ | ☐ | Nasal drainage | _____ |

| NO | YES | **Cardiovascular** | **Comment** |
|---|---|---|---|
| ☐ | ☐ | Chest pain | _____ |
| ☐ | ☐ | Irregular heart beat | _____ |

| NO | YES | **Respiratory** | **Comment** |
|---|---|---|---|
| ☐ | ☐ | Shortness of breath | _____ |
| ☐ | ☐ | Wheezing | _____ |

| NO | YES | **Gastrointestinal (G.I.)** | **Comment** |
|---|---|---|---|
| ☐ | ☐ | Abdominal pain | _____ |
| ☐ | ☐ | Diarrhea | _____ |
| ☐ | ☐ | Constipation | _____ |
| ☐ | ☐ | Vomiting | _____ |

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| NO | YES | Genitourinary (G.U.) | Comment |
|---|---|---|---|
| ☐ | ☐ | Pain or difficulty with urination | _____ |
| ☐ | ☐ | Blood or discoloration in urine | _____ |

ol

| NO | YES | Musculoskeletal | Comment |
|---|---|---|---|
| ☐ | ☐ | Joint Pain or swelling | _____ |
| ☐ | ☐ | Muscle pain or weakness | _____ |

| NO | YES | Integumentary (Skin) | Comment |
|---|---|---|---|
| ☐ | ☐ | Rash | _____ |
| ☐ | ☐ | Itching | _____ |

| NO | YES | Neurological | Comment |
|---|---|---|---|
| ☐ | ☐ | Headache | _____ |
| ☐ | ☐ | Dizziness | _____ |
| ☐ | ☐ | Weakness or gait disturbance | _____ |
| ☐ | ☐ | Numbness or tingling | _____ |

| NO | YES | Psychiatric | Comment |
|---|---|---|---|
| ☐ | ☐ | Anxiety | _____ |
| ☐ | ☐ | Depression | _____ |
| ☐ | ☐ | Emotional changes | _____ |
| ☐ | ☐ | Inconsolable | _____ |

| NO | YES | Endocrine | Comment |
|---|---|---|---|
| ☐ | ☐ | Change in sleep or eating | _____ |
| ☐ | ☐ | Cold or heat intolerance | _____ |
| ☐ | ☐ | Abnormality in growth or development | _____ |

| NO | YES | Hematologic/ Lymphatic | Comment |
|---|---|---|---|
| ☐ | ☐ | Frequent bruising or bleeding | _____ |
| ☐ | ☐ | Frequent infections | _____ |

| NO | YES | Allergic/ Immunologic | Comment |
|---|---|---|---|
| ☐ | ☐ | Environmental or food allergies | _____ |