LECOM Health Ophthalmology

Sterrettania Ophthalmology
4000 Sterrettania Road
814-836-0543

Eastside Medical Center
2625 Parade Street
814-452-6383

Plaza 18 Medical Center
537 West 18th Street
814-456-1009

Patient Name: _____ **Date of Birth: _____**

New Patient Questionnaire

Your answers will be used by your healthcare provider get an accurate history of your medical conditions and ocular concerns. If you are uncomfortable with any question, you do not have to answer it.

What is the reason for today's visit: _____

_____

Current Eye Symptoms:

Please check any symptoms that you are currently experiencing or have been experiencing that led you to schedule an appointment with the eye doctor.

- ❑ Blurred vision
- ❑ Problems with distance vision
- ❑ Problems with near vision
- ❑ Fluctuating vision
- ❑ Missing fields of vision
- ❑ Tearing
- ❑ Burning of eyes
- ❑ Itching of eyes
- ❑ Eye redness
- ❑ Eye / eyelid swelling
- ❑ Eye pain
- ❑ Light sensitivity
- ❑ Headache
- ❑ New floaters
- ❑ Flashes of light

Date and location of last eye exam: _____

If you currently wear glasses, how old is your current pair? _____

Are you interested in getting a new prescription for glasses today? ☐**Yes** ☐**No**

Current Eye Drops & Medications:

Please list any eye drops and eye medications that your are currently using and how often you are using them. If you do not know the specific name, you can describe the eye drop or what you are using it for.

Eye drop name or type of medication	**How many times of day?** (Ex. 1-2 times every day, as needed)

☐No eye drops or medications at this time.

Past Ocular History:

LECOM Health Ophthalmology

Sterrettania Ophthalmology
4000 Sterrettania Road
814-836-0543

Eastside Medical Center
2625 Parade Street
814-452-6383

Plaza 18 Medical Center
537 West 18th Street
814-456-1009

Do you have now (current) or have ever had (past) any of the following conditions or surgeries?

❑ Cataracts	❑ Macular edema	❑ Cataract surgery
❑ Glaucoma	❑ Macular pucker or epiretinal membrane	❑ Retinal surgery (ex. laser, vitrectomy)
❑ Macular degeneration	❑ Retinal tear or detachment	❑ Glaucoma surgery (ex. Laser, tube shunt)
❑ Diabetic eye disease	❑ Iritis / Uveitis	❑ No ocular diseases or history of eye surgery

Other ocular conditions or surgical procedures: _____

_____

Family Ocular History:
Please indicate which relative has had the following diseases (parents and siblings are most important).

Disease	Mother	Father	Sister(s)	Brother(s)	Maternal grandparent	Paternal grandparent	Other relative
Glaucoma							
Macular Degeneration							
Retinal tear or detachment							
Unexplained vision loss							

☐Family history unknown

Were you adopted? ☐Yes ☐No

Social History:

Do you currently smoke? ☐Yes ☐No Packer per day: _____ Number or years: _____

Have you ever smoked? ☐Yes ☐No When did you quit smoking? _____

Do you drink caffeine? ☐Yes ☐No Do you use recreational drugs? ☐Yes ☐No

New Patient Questionnaire

LECOM Health Ophthalmology

Sterrettania Ophthalmology
4000 Sterrettania Road
814-836-0543

Eastside Medical Center
2625 Parade Street
814-452-6383

Plaza 18 Medical Center
537 West 18th Street
814-456-1009

Please check any symptoms that you are currently experiencing.

General:
- ❑ Unexplained weight loss or weight gain
- ❑ Unexplained fevers
- ❑ Fatigue
- ❑ Weakness
- ❑ No problems

Eyes:
- ❑ Blurred vision
- ❑ Double vision
- ❑ Excessive tearing
- ❑ Eye pain or redness
- ❑ Light sensitivity
- ❑ No problems

Ear / Nose / Throat:
- ❑ Sinus infections
- ❑ Sore throat
- ❑ Trouble swallowing
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ No problems

Respiratory:
- ❑ Cough
- ❑ Loud snoring
- ❑ Sleep apnea
- ❑ No problems

Cardiovascular:
- ❑ Chest pain
- ❑ Irregular heartbeat
- ❑ Shortness of breath
- ❑ No problems

Gastrointestinal:
- ❑ Abdominal pain
- ❑ Loss of appetite
- ❑ Trouble swallowing
- ❑ No problems

Musculoskeletal:
- ❑ Arthritis
- ❑ Joint stiffness
- ❑ Back pain
- ❑ No problems

Psychiatric:
- ❑ Anxiety or stress
- ❑ Depression
- ❑ Change in mood
- ❑ No problems

Skin:
- ❑ Rash
- ❑ Itching
- ❑ New/changing mole
- ❑ No problems

Neurological:
- ❑ Headaches
- ❑ Ringing in ears
- ❑ Numbness or tingling
- ❑ No problems

Endocrine:
- ❑ Hot or cold intolerance
- ❑ Thyroid dysfunction
- ❑ High blood sugars
- ❑ No problems

Hematologic/Lymphatic:
- ❑ Easy bruising
- ❑ Easy bleeding
- ❑ Swollen lymph nodes
- ❑ No problems

Allergic:
- ❑ Runny nose
- ❑ Itchy eyes
- ❑ Seasonal allergies
- ❑ No problems

Genitourinary (female):
- ❑ Breast masses or lumps
- ❑ Bladder problems
- ❑ No problems

Genitourinary (male):
- ❑ Frequent urination
- ❑ History of Flomax use
- ❑ No problems

Personal Medical History

LECOM Health Ophthalmology

Sterrettania Ophthalmology
4000 Sterrettania Road
814-836-0543

Eastside Medical Center
2625 Parade Street
814-452-6383

Plaza 18 Medical Center
537 West 18th Street
814-456-1009

Do you have now (current) or have ever had (past) any of the following conditions?

❑ Acid reflux	❑ Depression	❑ Migraines
❑ Anemia	❑ Dermatitis	❑ Multiple sclerosis
❑ Aneurysm	❑ Diabetes	❑ Myocardial infarction (heart attack)
❑ Anxiety	❑ Epilepsy or seizures	❑ Osteoarthritis
❑ Arthritis	❑ Fibromyalgia	❑ Osteoporosis
❑ Asthma	❑ Gallstones	❑ Pneumonia
❑ Atrial fibrillation	❑ Gout	❑ Prostate cancer
❑ Back problems	❑ Headaches	❑ Psoriasis
❑ Benign prostatic hypertrophy (BPH)	❑ Hepatitis	❑ Rheumatoid arthritis
❑ Blood clots or DVT	❑ HIV	❑ Sjogren's syndrome
❑ Breast cancer	❑ Hypertension (high blood pressure)	❑ Stomach ulcers
❑ Cancer Type: _____	❑ Hyperlipidemia (high cholesterol)	❑ Stroke
❑ Colitis	❑ Iritis	❑ TIA
❑ Coronary artery disease	❑ Kidney disease	❑ Thyroid disease
❑ COPD	❑ Kidney stones	❑ Tuberculosis
❑ Crohn’s disease	❑ Lupus	❑ Urinary tract infections
❑ Dementia	❑ Mental illness	❑ Uveitis

List all surgeries and procedures that you have had in the past: _____

_____

_____

LECOM Health Ophthalmology

Sterrettania Ophthalmology
4000 Sterrettania Road
814-836-0543

Eastside Medical Center
2625 Parade Street
814-452-6383

Plaza 18 Medical Center
537 West 18th Street
814-456-1009

MEDICATIONS: Please list (or attach a photocopy) of all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs, inhalers, etc.

Name of Medication	Dosage	Times per day

☐ Medication list attached

Allergies to Medications or Food (include type of reaction)**:** ☐ **No Known Allergies**

_____

_____

_____

_____

LECOM Health Ophthalmology

Sterrettania Ophthalmology
4000 Sterrettania Road
814-836-0543

Eastside Medical Center
2625 Parade Street
814-452-6383

Plaza 18 Medical Center
537 West 18th Street
814-456-1009

Patient Name: _____ **Date of Birth: _____**

Established Patient Questionnaire

Your answers will be used by your healthcare provider get an accurate history of your medical conditions and ocular concerns. If you are uncomfortable with any question, you do not have to answer it.

What is the reason for today's visit: _____

Current Eye Drops:

Please list the eye drops and/or eye medications that your are currently using and how often you are using them. If you do not know the specific name, you can describe the eye drop or what you are using it for (ex. antibiotic, steroid, red cap, blue cap, eye itching, infection, etc).

Eye drop name or description	**How many times a day?** (Ex. 1-2 times every day, as needed)

Medical and Surgical History:

Please list any new medical diagnoses, hospitalizations, or surgeries since your last visit.

_____

_____

_____

Current Eye Symptoms:

Please check any symptoms that you are currently experiencing or any symptoms that are <u>new</u> since the time of your last visit to the eye doctor.

- ❑ Blurred vision
- ❑ Problems with distance vision
- ❑ Tearing
- ❑ Burning of eyes
- ❑ Eye pain
- ❑ Light sensitivity

LECOM Health Ophthalmology

Sterrettania Ophthalmology
4000 Sterrettania Road
814-836-0543

Eastside Medical Center
2625 Parade Street
814-452-6383

Plaza 18 Medical Center
537 West 18th Street
814-456-1009

- ❑ Problems with near vision
- ❑ Fluctuating vision
- ❑ Missing fields of vision
- ❑ Itching of eyes
- ❑ Eye redness
- ❑ Eye / eyelid swelling
- ❑ Headache
- ❑ New floaters
- ❑ Flashes of light

Established Patient Questionnaire

Please check any symptoms that are <u>new</u> since the time of your last visit to the eye doctor.

<u>General</u>:
- ❑ Unexplained weight loss or weight gain
- ❑ Unexplained fevers
- ❑ Fatigue
- ❑ Weakness
- ❑ No problems

<u>Eyes</u>:
- ❑ Blurred vision
- ❑ Double vision
- ❑ Excessive tearing
- ❑ Eye pain or redness
- ❑ Light sensitivity
- ❑ No problems

<u>Ear / Nose / Throat</u>:
- ❑ Sinus infections
- ❑ Sore throat
- ❑ Trouble swallowing
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ No problems

<u>Respiratory</u>:
- ❑ Cough
- ❑ Loud snoring
- ❑ Sleep apnea
- ❑ No problems

<u>Cardiovascular</u>:
- ❑ Chest pain
- ❑ Irregular heartbeat
- ❑ Shortness of breath
- ❑ No problems

<u>Gastrointestinal</u>:
- ❑ Abdominal pain
- ❑ Loss of appetite
- ❑ Trouble swallowing
- ❑ No problems

<u>Musculoskeletal</u>:
- ❑ Arthritis
- ❑ Joint stiffness
- ❑ Back pain
- ❑ No problems

<u>Psychiatric</u>:
- ❑ Anxiety or stress
- ❑ Depression
- ❑ Change in mood
- ❑ No problems

<u>Skin</u>:
- ❑ Rash
- ❑ Itching
- ❑ New/changing mole
- ❑ No problems

<u>Neurological</u>:
- ❑ Headaches
- ❑ Ringing in ears
- ❑ Numbness or tingling
- ❑ No problems

<u>Endocrine</u>:
- ❑ Hot or cold intolerance
- ❑ Thyroid dysfunction
- ❑ No problems

<u>Hematologic/Lymphatic</u>:
- ❑ Easy bruising or bleeding
- ❑ Swollen lymph nodes
- ❑ No problems

<u>Allergic</u>:
- ❑ Runny nose
- ❑ Itchy eyes
- ❑ Seasonal allergies
- ❑ No problems

<u>Genitourinary (female)</u>:
- ❑ Breast masses or lumps
- ❑ Bladder problems
- ❑ No problems

<u>Genitourinary (male)</u>:
- ❑ Frequent urination
- ❑ History of Flomax use
- ❑ No problems