NEWTON-WELLESLEY EYE ASSOCIATES, P.C.

NAME ____ DOB _____/_____/_____ DATE ______________________

Primary reason for visit: ____

Major medical illnesses: ____

Previous operations: ____

Current medications (include aspirin products): ____

____

Allergies (medications or environmental): ____

Do you drive? Y / N Do you smoke? Y / N Have you ever smoked? Y/N Do you drink alcohol? Y / N

Does your vision limit any activities of daily living (ie, driving, reading, sports, work)? ____________________________

____

Usual occupation: ____ Daily hours on computer: ___________________

Hobbies: ____

Recent travel: ____

Please indicate if you have or have had any of the following:

	NO	YES
Heart disease		
Lung disease		
Shortness of breath		
Cough/Wheeze/Asthma		
Abnormal chest x-ray		
Tuberculosis		
Thyroid disease		
Diarrhea/Constipation		
Colitis/Inflammatory bowel		
Liver disease/Hepatitis		
Easy bleeding/Bruising		
Kidney disease		

	NO	YES
Arthritis/Autoimmune disease		
Lyme disease		
Neurologic disease/numbness		
Stroke/Paralysis		
Migraines		
Psychiatric (Depression/Anxiety)		
Immune compromised		
Fever		
Fatigue		
Unexplained weight loss		
Cancer/Tumor		
Skin cancer		

Family History – Please indicate family members with the following by specifying:

Mother (**M**) Father (**F**) Brother (**B**) Sister (**S**) Maternal Grandmother (**MGM**) Maternal Grandfather (**MGF**) Paternal Grandmother (**PGM**) Paternal Grandfather (**PGF**) Maternal Aunt (**MA**) Maternal Uncle (**MU**) Paternal Aunt (**PA**) Paternal Uncle (**PU**)

Blindness ________________________________
Glaucoma ________________________________
Macular/retinal degeneration ____________________
Retinal detachment ___________________________
Diabetes ☐ Type 1 ☐ Type 2 ____________________

Lazy eye ________________________________
Misaligned eyes ____________________________
Migraine ________________________________
Autoimmune disease __________________________
Thyroid disease ______________________________

____ ____

Patient/ Parent/Legal Guardian Signature *Date*

I have reviewed the above information and: ☐ **Confirm there are no changes** ☐ **Have marked changes in red** ___________________

Reviewed by _________________________________ M.D./O.D. Date(s) _________________________________

10/2015