Alberta Eye Care New Patient Questionnaire

Thank you for visiting our office. At Alberta Eye Care, we take great care to make sure we provide you with the highest level of healthcare service. To assist us in the providing you with the best care possible, we need to have a comprehensive understanding of your personal and family health history. Please fill out the questionnaire with the best information that you can provide. Your answers will remain confidential and will not be shared or sold at any point, as we are bound by HIPAA to protect your privacy…and we take that stuff seriously!

PATIENT NAME _____ (circle): Mr. Mrs. Ms. Miss. Dr.

Occupation _____ **Employer** _____

Nickname _____ **E-mail address** _____

Year of last eye exam _____ at (Clinic or Doctor)_____

Have you previously had eye surgery, including LASIK, PRK or RK? Yes / No

List your general medical doctor, his/her clinic and phone number

Dr._____at _____ **phone** _____

Tell us about <u>YOUR</u> health. Do you have any of the conditions listed below? List any current medications (prescribed or over the counter) or treatments, even if unrelated to the eyes.

	Yes	**No**	**List Medications or Treatments**
Cancer, type _____	___	___	_____
ENT: Sinus, throat, hearing loss, etc	___	___	_____
Neuro: Epilepsy, stroke, migraine	___	___	_____
Psychiatric: Anxiety, depression, etc	___	___	_____
Cardiovascular: High blood pressure	___	___	_____
high cholesterol, heart condition	___	___	_____
Respiratory: Asthma, sleep apnea	___	___	_____
GI: Ulcer, Crohns, Celiac	___	___	_____
GU: Kidney disease, prostate, STD	___	___	_____
Musculoskeletal: Arthritis,	___	___	_____
fibromyalgia	___	___	_____
Skin: Eczema, rosacea, herpes, etc	___	___	_____
Endocrine: Diabetes, thyroid,	___	___	_____
birth control, hormones	___	___	_____
Hematologic: anemia	___	___	_____
Immune: Lupus, seasonal allergies	___	___	_____
Other_____	___	___	_____

Are you:	(please circle)	
Pregnant/breastfeeding	No	Yes
Allergic to latex?	No	Yes
Allergic to medications	No	Yes
If yes, please list below:		

___ I do not have any of the above, or other health conditions, or take any medications.

Do you drink alcohol? (please circle): Yes / No If yes, how many drinks per week? _____

Do you smoke? (please circle): Yes Not now Never If yes, how do you smoke and how often? _____

Height _____ **Weight** _____

Preferred language: _____ **Ethnicity** (please circle): Hispanic or Latino Not Hispanic or Latino

Race (please circle): White/Caucasian Black/African American Indian: Continent of India American Indian/Alaska Native Asian Native Hawaiian or other Pacific Islander Other race: _____

SIDE 2. PATIENT NAME _____

Tell us about your <u>FAMILY</u> health. Has anyone in your family had any of the conditions listed below?

	Yes	No	Family Member
Cancer, type _____	___	___	_____
Cardiovascular: High blood pressure	___	___	_____
high cholesterol, heart condition	___	___	_____
Endocrine: Diabetes, thyroid,	___	___	_____
Other_____	___	___	

Has anyone in your <u>FAMILY</u> has had these or other eye conditions? Please list which family member.

	Yes	No	Family Member
Cataracts	___	___	_____
Macular degeneration	___	___	_____
Glaucoma	___	___	_____
Crossed or lazy eye	___	___	_____
Blindness (even later in life)	___	___	_____
Other_____	___	___	_____

<u>PHR Interview Questions</u>

What is your reason for visiting us today? _____

Have <u>YOU</u> ever been diagnosed with any of the following conditions?

	Yes	No		Yes	No
Cataracts	___	___	Dry eye	___	___
Macular degeneration	___	___	Eye infection, inflammation, or allergy	___	___
Glaucoma	___	___	Floater, and/or flashes of light	___	___
Diabetes	___	___	Iritis or uveitis	___	___
Diabetic retinopathy	___	___	Retina defects or degenerations	___	___

Other _____

Are you having any of the following eye/vision concerns?

	Yes	No		Yes	No
Redness	___	___	Eye pain	___	___
Burning	___	___	Severe sensitivity to lights	___	___
Itching	___	___	Headache	___	___
Tearing	___	___	Poor night vision	___	___
Discharge	___	___	Bothersome night glare	___	___
Blurred vision	___	___	Double vision	___	___
Eyestrain	___	___	Total loss of vision	___	___

Other _____

What are you mainly using for *distance* vision activities?	No Correction	Eyeglasses	Contact Lenses (CL)	
Describe the quality of your *distance* vision activities:	Acceptable	May Need Improvement		Blurred
What are you mainly using for *near/reading* vision activities?	No Correction	Eyeglasses	Contact Lenses	CL & Readers
Describe the quality of your *near/reading* vision activities:	Acceptable	May Need Improvement		Blurred
What are you mainly using for *computer* vision activities?	No Correction	Eyeglasses	Contact Lenses	CL & Readers
Describe the quality of your *computer* vision activities:	Acceptable	May Need Improvement		Blurred