



NOBBE EYE CARE

a division of CHITTICK EYE CARE

Exam Date: ____ / ____ / ____

Date of Birth: ____ / ____ / ____

Patient Name: _____

New Patient History Form

Welcome to **Nobbe** Eye Care Center! We are pleased that you have chosen us as your primary eye care provider. Please fill out this form to the best of your ability. Our dedicated team is here to assist you with any questions.

Ocular History

Have you ever been diagnosed with any of the following conditions?

- | | | |
|---|---|---|
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Floaters and/or Flashes of Light |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Iritis or Uveitis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Eye Infection/
Allergy/Inflammation | <input type="checkbox"/> Retina defects |

Do you have any of the following eye concerns?

- Redness Burning Itching Tearing Discharge

Please list any additional concerns: _____

Do you have any of the following vision concerns?

- | | | |
|---|--|---|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Severe Sensitivity to Light | <input type="checkbox"/> Night Glare |
| <input type="checkbox"/> Eyestrain | <input type="checkbox"/> Headache | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Poor Night Vision | <input type="checkbox"/> Total Loss of Vision |

Please list any additional concerns: _____

GLASSES HISTORY

- | | | |
|--|-----|----|
| Are you planning to get new glasses today? | Yes | No |
| Do you currently wear glasses? | Yes | No |
| Do you wear sunglasses? | Yes | No |
| Are your sunglasses your most recent prescription? | Yes | No |

CONTACT LENS HISTORY

- | | | |
|---|-----|------------------------------|
| Are you interested in trying contact lenses today? | Yes | No |
| Do you currently wear contact lenses? | Yes | No |
| If not currently wearing contact lenses, have you tried before? | Yes | No Why did you stop? _____ |

Medical History

Primary Care Physician: _____ Specialist: _____

Are you allergic to any medications: Yes No If yes, which ones: _____

List any major surgeries: _____

Do you Smoke? Yes No Do you drink alcohol? Yes No Do you drive? Yes No

Are you pregnant or nursing? Yes No

If you have ever been exposed to HIV, Hepatitis, Tuberculosis, Chlamydia, or Gonorrhea please discuss with your doctor.

Current Medications including eye drops:

- 1. _____ for _____
- 2. _____ for _____
- 3. _____ for _____
- 4. _____ for _____
- 5. _____ for _____
- 6. _____ for _____
- 7. _____ for _____
- 8. _____ for _____
- 9. _____ for _____
- 10. _____ for _____

List any cancers and any treatment you may have received: _____

Review of Systems

Please mark beside any problem you currently have or have had in the following categories.

Constitutional

- Developmental Disabilities
- Cancer
- Fatigue Syndrome

ENT

- Hearing Loss
- Sinusitis
- Dry Mouth
- Laryngitis

Neurological

- Multiple Sclerosis
- Epilepsy
- Cerebral Palsy
- Tumor
- Stroke/CVA
- Migraine

Psychological

- Depression
- Attention Deficit
- Anxiety Disorder
- Bipolar Disorder

Cardiovascular

- Hypertension
- Stroke/CVA
- Heart Disease
- Vascular Disease
- Congestive Heart Failure

Respiratory

- Asthma
- Bronchitis
- Emphysema
- Chronic Obstruction
- Sleep Apnea

Gastrointestinal

- Crohn's
- Colitis
- Ulcer
- Acid Reflux
- Celiac Disease

Genitourinary

- Kidney Disease
- Prostate disease/cancer

Musculoskeletal

- Arthritis
- Osteoarthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis
- Osteoporosis
- Gout

Integumentary

- Eczema
- Rosacea
- Psoriasis
- Herpes Simplex/Cold Sores
- Herpes Zoster/Shingles

Endocrine

- Type 2 Diabetes Mellitus
- Type 1 Diabetes Mellitus
- Thyroid dysfunction
- Hormonal dysfunction

Hematologic/Lymphatic

- Anemia
- Large-volume blood loss
- Ulcer
- High Cholesterol

Allergic/Immune

- Drug Allergies
- Environmental Allergies
- Rheumatoid Arthritis
- Lupus
- Sjogren's Syndrome

Family History

Please list parents, grandparents, siblings, or children - living or deceased with the following conditions:

- | | |
|---|--|
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Cataract _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Lazy Eye _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Macular Degeneration _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Color Blindness _____ | <input type="checkbox"/> Lupus _____ |
| <input type="checkbox"/> Retinal Detachment _____ | <input type="checkbox"/> Thyroid Disease _____ |