NEW PATIENT INFORMATION SHEET

NAME:_____ DATE:_____

Please fill out this form completely including DATES, PLACES, and DOCTORS, and bring it with you on the day of your appointment along with your medications. Thank you.

ALLERGIES (medication, latex, etc.)	
Allergic to:	Reaction

SOCIAL HISTORY	
Do you smoke? Y or N	
Amount	Years
Do you drink alcohol? Y or N	
Amount	Years
Do you drink caffeine? Y or N	
Amount per day	

EYE MEDICATION					
Name	Strength	Start Date	Stop Date	Dosage & Times per day	Reason

OTHER MEDICATION INCLUDING VITAMINS (continue on back if necessary)					
Name	Strength	Start Date	Stop Date	Dosage & Times per day	Reason

MEDICAL HISTORY	
Diagnosis	Years

EYE HISTORY		
Diagnosis	Eye	Years

SURGICAL HISTORY (please indicate Right or Left when applicable)			
Surgical Procedure	Reason/Diagnosis	Date of Surgery	Surgeon

FAMILY EYE & MEDICAL HISTORY (cataracts, glaucoma, diabetes, cancer, hear problems, etc.)	
Family Member(s)	Diagnosis

Most recent eye exam: _____ **Doctor:** _____

MEDICATIONS (continued from front)

Name	Strength	Start Date	Stop Date	Dosage & Times per day	Reason

ADDITIONAL INFORMATION