Dr. Edward Maslansky

New Patient Form

Date:_____/_____/_____

Patient Name: _____ DOB: _____/_____/_____

Address: _____ CITY: _____

State: _____ Zip: _____ Email: _____

Phone:_____ Cell Phone: _____

Date of Last Eye Exam: _____/_____/_____ Social Security Number:_____

Primary Physician:_____Date Last Medical Exam: ____/____/____

Occupation: _____ Hobbies: _____

Are you currently pregnant or nursing? Yes No N/A

Do you wear glasses? Yes No

Are they for Near Vision? Yes No

Are they for Distance Vision? Yes No

Any problems with Near Vision with our without glasses? Yes No

Any problems with Distance Vision with our without glasses? Yes No

Do You Wear Contacts? Yes No

What type of Lenses do you wear? Soft_____ Disposable_____ Dailies_____Extended Wear_____

Bifocal _____ Gas Permeable_____ Hard Lenses_____

Are you happy with your current lenses: Yes No

Wearing Schedule: Daily / Overnight

Solution Used: _____

VISUAL CONCERNS:

HEADACHES: YES / NO How long have you had them? _____

PAIN IN EYE: YES / NO Right_____ Left_____ Both____

Where is Pain Located: _____ How Long? _____

DOUBLE VISION: YES / NO **SPOTS:** YES / NO **FLASHES:** YES / NO

DRY EYES: YES / NO **BURNING EYES:** YES / NO **OTHER:** YES / NO_____

PRIOR DIAGNOSES OR PROBLEMS: _____

Personal Medical History: (Review of Systems): Please check if any of the following applies to you past or present and list all medications below. If you have none of these conditions, please check NONE.

Cardiovascular: _____None _____High Blood Pressure _____High Cholesterol _____Heart Disease _____Vascular Disease _____Stroke _____Other:	**Endocrine:** _____None _____Type 2 Diabetes _____Type 1 Diabetes _____Thyroid Problem _____Hormonal Dysfunction _____Other **Constitutional:** _____None _____Cancer – Type_____ _____Trauma/Large Volume Blood Loss _____Developmental Disability _____Other:	Respiritory: _____None _____Asthma _____Bronchitis _____Emphysemia _____COPD _____Other:
Neurological: _____None _____Multiple Sclerosis _____Epilepsy/Seizure Disorder _____Cerebral Palsy _____Tumor _____Migraines/Headache Disorder _____Other:	**Musculoskeletal:** _____None _____Arthritis _____Fibromyalgia _____Muscular Dystrophy _____Anklosing Spondylitis _____Other:	**Immunological:** _____None _____AIDS or HIV _____Lupus _____Neurological
Heomatological: _____None _____Anemia _____Leukemia _____Other:	**Gastrointestinal:** _____None _____Chrone's _____Colitis _____Other:	**Ear/Nose/Throat:** _____None _____Hearing Loss _____Upper Respiratory Infection _____Other:
Dermatologic: _____None _____Eczema _____Rosacea _____Psoriasis _____Skin Cancer _____Other:	**Allergies (please list)** _____None Drug/Medication: Environmental: Other:	**Alcohol Use:** Y N Amount: **Tobacco Use:** Current/ Past / Never Amount: Number of Years:

Please list any medications that you are taking or ask our staff to make a copy of your medication list. (Including vitamin, herbs, supplements and over the counter)

1._____ 6._____

2._____ 7. _____

3._____ 8._____

4._____ 9._____

5._____ 10._____

FAMILY HISTORY: Has anyone in your immediate family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

Disease/Condition		**Relationship**			**Relationship**
Lupus:	Yes/No	_____	Blindness:	Yes/No	_____
High Blood Pressure:	Yes/No	_____	Cataracts:	Yes/No	_____
Diabetes:	Yes/No	_____	Glaucoma:	Yes/No	_____
Heart Disease:	Yes/No	_____	Crossed Eyes:	Yes/No	_____
Thyroid Disease:	Yes/No	_____	Macular Degeneration:	Yes/No	_____
Cancer: (Type)	Yes/No	_____	Retinal Detachment:	Yes/No	_____
			Other:	Yes/No	_____

Patient Signature _____ **Date**_____