the eye studio yxe – New Patient Information

Title:______ Name:____ DOB: (MM/DD/YY) ____________________

Health Card #_____________________________________ Pronouns ________________ Legal Sex (circle one) M / F

Address:______________________________________ City:_____________________ Postal Code:______________

Phone Number (Cell):________________________________ (Work/Home):________________________________

Email Address: ____

Family Doctor:___________________ Last Eye Exam:________ Last Optometrist:______________________________

Occupation:_________________________________ Hobbies:____

REASON FOR TODAY'S VISIT:

PERSONAL EYE HISTORY: Please circle yes or no and elaborate if necessary.

(Yes / No) Do you wear sunglasses? If you answered 'yes', do you wear prescription sunglasses (Yes / No)?
(Yes / No) Do you wear glasses?
(Yes / No) Do you wear contact lenses? If you answered 'no', are you interested in trying them (Yes / No)? (please circle one)
(Yes / No) Do you experience double vision, eye strain or blur? (circle which apply)
(Yes / No) Do you use a computer? If yes, __________hours a day?
(Yes / No) Do you have dry eyes? If you answered 'yes', please answer these questions:
A) What do you do for relief? eye drops / lid wipes / hot compresses / nothing / other
B) Would you like to explore alternative options to help with your dry eyes (Yes / No)?
(Yes / No) Do you get migraines or headaches (circle which apply)? If yes, _________times a month?
(Yes / No) Are you being monitored for any eye conditions? If so, which one(s) and by who?
____
(Yes / No) Have you ever had eye surgery? If so, when, for what and with which surgeon?
____
(Yes / No) Are you interested in laser eye surgery?
(Yes / No) Are there any other eye issues you wanted to bring up with the doctor? ______________________

MEDICATIONS:

(Yes / No) Do you take any supplements/vitamins? If yes, please list them here:__________________________
(Yes / No) Do you use any eye drops? If yes, please list them here: ____________________________________
(Yes / No) Do you take any medications? If yes, please list them here: __________________________________

PERSONAL MEDICAL HISTORY: Do YOU have any of the following (please circle yes or no)

(Yes / No) High or low blood pressure?(Yes / No)
(Yes / No) Heart problems?_________________________
(Yes / No) Diabetes? If yes, Type 1 or Type 2? (circle one)
(Yes / No) Gastrointestinal/stomach problems?__________
(Yes / No) A history of OR a current tobacco user?
(Yes / No) Arthritis? If yes, what kind?_________
(Yes / No) High Cholesterol?
(Yes / No) Thyroid problems?
(Yes / No) Lung/Asthma/COPD?
(Yes / No) Allergies?
(Yes / No) Other Medical Conditions (list):____
(Yes / No) Women, are you pregnant and/or nursing?

FAMILY HISTORY: Please circle if any conditions run in your immediate family below; if yes, indicate *WHICH RELATIVE & WHICH SIDE OF THE FAMILY*:

(Yes / No) Glaucoma? ____________________________
(Yes / No) Macular Degeneration? __________________
(Yes / No) Retinal Detachment? ____________________
(Yes / No) OTHER Eye Conditions? _________________
(Yes / No) Diabetes? __________________
(Yes / No) High Blood Pressure? ________
(Yes / No) OTHER Medical Conditions?___

How'd You Hear About Us?______________________________

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The eye studio yxe – Consent to use Personal Health Information

How did you want to receive the following information?

	EMAIL	TEXT	PHONE CALL	MAIL	N/A
Appointment Reminders?	☐	☐	☐	☐	
Yearly/Biennial Appointment Recalls?	☐	☐	☐	☐	☐
Order Notifications?	☐	☐	☐		
Educational Information?	☐			☐	
Marketing Information?	☐			☐	
Clinic Newsletters?	☐			☐	

______________________________ **Signature**

______________________________ **Date**