JENNINGS EYE ASSOCIATES
New Patient Form

General Information

Name: ______________________________________ Today's Date: ___________________

Address: ____________________________________ Phone: __________________ c / h / w

City: ____________________ State: ______ Zip: ________ Email: _________________________

DOB: _____ / _____ / ________ Last Four of SS#: ________ Male / Female

Marital Status: Married | Single | Divorced | Legally Separated | Widowed

Occupation / Employer: ____ Full-time | Part- time

Language: _______________ Race: _______________________ Ethnicity: __________________

Primary Care Physician: ____

Emergency Contact: _______________________________ Phone: _________________________

Insurance Information

Vision Insurance Type: __________________ Member ID (if applicable): ______________________

Primary Member Name: ____________________________ Relationship: ____________________

Primary Member DOB: _____ / _____ / _________ Primary Member Last Four SSN: _______________

Medical Insurance Type: _____________________ Member ID: ___________________________

Primary Member Name: ____________________________ Relationship: ____________________

Primary Member DOB: _____ / _____ / _________ Primary Member Last Four SSN: _______________

Medical History

Current Medications (including oral contraceptives, aspirin, OTC medications, home remedies, eye drops):

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Medication Allergies (please explain):____

Major Surgeries: ____

Height: ______________ Weight: _____________ Are you pregnant/nursing? ☐ Yes ☐ No

Social History - this information is kept strictly confidential, you may discuss in private with your doctor

Do you use tobacco? ☐ Yes ☐ No If yes, type/amount: _____________________________________

Have you previously smoked? ☐ Yes ☐ No If yes, when did you quit? _______________________

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount:

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Have you ever been exposed to or infected with: ☐ HIV ☐ Hepatitis ☐ Syphilis ☐ Gonorrhea

Ocular History

Date of Last Eye Exam: _____ / _____ / _________ Reason for visit: ________________________

Do you wear glasses? ☐ Yes ☐ No If yes, when was the Rx issued? _____________________

Do you wear contact lenses? ☐ Yes ☐ No If yes, when was the Rx issued? _________________

Type of contact lenses worn: ☐ Soft lenses ☐ Rigid Gas Permeable ☐ Hybrid ☐ Other:

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Circle any of the following that you have had: Eye Injury | Eye Surgery | Eye Infections | Lazy Eye

Family History - Have any relatives (blood related), living or deceased, had any of the following conditions?

Condition		Relationship
Cataracts	☐ Yes ☐ No	Relationship: ________________
Crossed Eye	☐ Yes ☐ No	Relationship: ________________
Glaucoma	☐ Yes ☐ No	Relationship: ________________
Lazy Eye	☐ Yes ☐ No	Relationship: ________________
Macular Degeneration	☐ Yes ☐ No	Relationship: ________________
Retinal Detachment	☐ Yes ☐ No	Relationship: ________________
Cancer	☐ Yes ☐ No	Relationship: ________________
Diabetes	☐ Yes ☐ No	Relationship: ________________
Heart Disease	☐ Yes ☐ No	Relationship: ________________
High Blood Pressure	☐ Yes ☐ No	Relationship: ________________
High Cholesterol	☐ Yes ☐ No	Relationship: ________________
Thyroid	☐ Yes ☐ No	Relationship: ________________

Other (please explain): ____

Review of Systems - Are you currently, or have experienced, any of the following?

Eyes

- Blurry vision ☐ Yes ☐ No
- Burning ☐ Yes ☐ No
- Discharge ☐ Yes ☐ No
- Double vision ☐ Yes ☐ No
- Dryness ☐ Yes ☐ No
- Excess watering ☐ Yes ☐ No
- Eye infection ☐ Yes ☐ No
- Eye pain ☐ Yes ☐ No
- Floaters or spots ☐ Yes ☐ No
- Halos ☐ Yes ☐ No
- Headaches ☐ Yes ☐ No
- Itching ☐ Yes ☐ No
- Light flashes ☐ Yes ☐ No
- Light sensitivity ☐ Yes ☐ No
- Redness ☐ Yes ☐ No
- Sandy/gritty feeling ☐ Yes ☐ No

Constitution

- Disability ☐ Yes ☐ No
- Cancer ☐ Yes ☐ No
- Fatigue ☐ Yes ☐ No

ENT

- Hearing loss ☐ Yes ☐ No
- Sinusitis ☐ Yes ☐ No
- Laryngitis ☐ Yes ☐ No

Gastrointestinal

- Crohn's ☐ Yes ☐ No
- Acid Reflux ☐ Yes ☐ No
- Celiac Disease ☐ Yes ☐ No
- IBS ☐ Yes ☐ No

Integumentary

- Eczema ☐ Yes ☐ No
- Rosacea ☐ Yes ☐ No
- Psoriasis ☐ Yes ☐ No

Musculoskeletal

- Arthritis ☐ Yes ☐ No
- Fibromyalgia ☐ Yes ☐ No

Neurological

- Migraine ☐ Yes ☐ No
- Epilepsy ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- Tumor ☐ Yes ☐ No

Psychiatric

- Bipolar disorder ☐ Yes ☐ No
- Depression ☐ Yes ☐ No
- ADHD ☐ Yes ☐ No
- Anxiety disorder ☐ Yes ☐ No

Cardiovascular

- Heart Disease ☐ Yes ☐ No
- High Blood Pressure ☐ Yes ☐ No
- Vascular Disease ☐ Yes ☐ No

Respiratory

- Asthma ☐ Yes ☐ No
- Bronchitis ☐ Yes ☐ No
- Emphysema ☐ Yes ☐ No

Genitourinary

- Kidney Disease ☐ Yes ☐ No
- Prostate Disease ☐ Yes ☐ No

Endocrine

- Diabetes ☐ Yes ☐ No
- Thyroid Dysfunction ☐ Yes ☐ No
- Hormone Condition ☐ Yes ☐ No

Lymphatic

- High Cholesterol ☐ Yes ☐ No
- Blood Disorder ☐ Yes ☐ No

Immune

- Allergies ☐ Yes ☐ No
- Rheumatoid Arthritis ☐ Yes ☐ No
- Lupus ☐ Yes ☐ No

Other - please explain any conditions not listed above

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