BEALS OPTOMETRY **New Patient History Form**

NAME: ______________________ Date of Birth: ______________ Today's Date: ____________

Reason for today's visit: ____

When was your last visit to an eye doctor: ____________________

What are your visual symptoms? (circle all that apply)

Blurry Vision-Distance	Burning Eyes	Floaters or Spots	Headaches
Blurry Vision-Near	Itchy Eyes	Seeing Flashes	Migraine Headaches
Double Vision	Dry Eyes	Poor Night Vision	Crossed/Turned Eyes
Eye Strain	Red Eye(s)	Light Sensitivity	Eye Infection
Watery Eyes	Sandy/Gritty Feeling	Droopy Lid	Eye Pain

Do you wear glasses? Yes No All the time / Sometimes / Work Only / Reading Only / Driving Only

Do you wear contact lenses? Yes No Type: ____________________

Do you smoke? Yes No Are you currently pregnant? Yes No Not Applicable

List current MEDICATIONS (or provide list): ____

List ALLERGIES: ____

DISEASE HISTORY: SELF or FAMILY

Please check the box if you have the disease or condition.

DISEASE/CONDITION	If relative, please explain who:
☐ Glaucoma	____________________
☐ Cataracts	____________________
☐ Macular Degeneration	____________________
☐ Retinal Detachment	____________________
☐ Crossed or Lazy Eye	____________________
☐ Other Eye Disease	____________________
☐ Diabetes A1c: ______	____________________
☐ Heart Disease	____________________
☐ High Blood Pressure	____________________
☐ Multiple Sclerosis	____________________
☐ Arthritis	____________________
☐ Asthma	____________________
☐ Lupus	____________________
☐ Anxiety/Psychological Condition	____________________
☐ Cancer	____________________
☐ OTHER: ____________	____________________

FOR OFFICE USE ONLY:

Review Date: ________	Review Date: ________	Review Date: ________	Review Date: ________	Review Date: ________
Provider: _____	Provider: _____	Provider: _____	Provider: _____	Provider: _____