Ritter Hagee Optometry New Patient History

Name:_____DOB_____

Occupation:_____Email Address:_____

Gender: ☐Male ☐Female Preferred Language: _____

Race: ☐Unknown ☐American Indian or Atlantic Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐Other Race ☐White

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Eye History

Do you presently wear glasses?

- ☐ Yes (For what purpose? _____)
- ☐ No

Do you presently wear contact lenses?

- ☐ Yes (Type? _____)
- ☐ No

Do you use any prescription eye drops? If so, please list: _____

Approximately how many hours per day do you spend on a computer? _____

Please list any hobbies or interests: _____

Past Ocular History

Please check if you have a history of any of the following eye problems:

- ☐ Dry eyes
- ☐ Patching
- ☐ Strabismus
- ☐ Retinal Detachment
- ☐ Glaucoma Suspect
- ☐ Amblyopia
- ☐ Glaucoma
- ☐ Eye Surgery
- ☐ Retinal Degeneration
- ☐ Inflammatory Disorder
- ☐ Eye Injury
- ☐ Macular Degeneration
- ☐ Cataract
- ☐ Retinal Hole
- ☐ Nystagmus
- ☐ Keratoconus
- ☐ Other:_____

Medical History

Please check if you have any of the following medical conditions:

Constitution:

- ☐ Fatigue Syndrome
- ☐ Developmental Disabilities
- ☐ Cancer

Ear, Nose and Throat:

- ☐ Sinusitis
- ☐ Hearing Loss
- ☐ Laryngitis
- ☐ Dry Mouth

Neurological:

- ☐ Migraines
- ☐ Tumor
- ☐ Cerebral Palsy
- ☐ Multiple Sclerosis
- ☐ Stroke / CVA
- ☐ Epilepsy

Psychiatric:

- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Attention Deficit Disorder

Cardiovascular:

- ☐ Heart Disease
- ☐ Congestive Heart Failure
- ☐ Vascular Disease
- ☐ Stroke / CVA
- ☐ Hypertension

Respiratory:

- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Bronchitis
- ☐ Asthma
- ☐ Chronic Obstruction
- ☐ Cigarette Smoker

Gastrointestinal:

- ☐ Ulcer
- ☐ Celiac Disease
- ☐ Crohn's
- ☐ Acid Reflux
- ☐ Colitis

Genitourinary:

- ☐ Benign Prostate Hypertrophy
- ☐ Chlamydia
- ☐ Nursing
- ☐ Kidney Disease
- ☐ STD- Herpes/Chlamydia
- ☐ Pregnant

Musculoskeletal:

- ☐ Osteoarthritis
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Ankylosing Spondylitis

Integumentary:

- ☐ Eczema
- ☐ Herpes Zoster/Shingles
- ☐ Rosacea
- ☐ Herpes Simplex/ Cold Sores
- ☐ Psoriasis

Endocrine:

- ☐ Thyroid dysfunction
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Hormonal Dysfunction

Hematologic/Lymphatic:

- ☐ Anemia
- ☐ Ulcer
- ☐ Large Volume Blood Loss
- ☐ Hypercholesteremia (elevated cholesterol)

Allergic/Immune

- ☐ Environmental Allergies
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Drug Allergies
- ☐ Sjogren's Syndrome

**Please list any other medical conditions that you may have that are not listed above: _____

☐ **I have no medical conditions**

Medications

Please list any medications (list dosages if possible) that you are currently taking:

☐ I take no medications.

_____

_____

Please list any medications to which you are allergic:

☐ I have no medication allergies.

_____

Please list any other allergies that you may have:

☐ I have no other allergies.

_____

Family Medical History

Please check if anyone in your immediate family (mother, father, brother or sister) has any of the following medical conditions:

- ☐ Cancer
- ☐ Hypertension
- ☐ Diabetes
- ☐ Thyroid dysfunction

Family Ocular History

Please check if anyone in your immediate family (parent, sibling or child) has any of the following eye conditions:

- ☐ Macular Degeneration
- ☐ Severe Hyperopia
- ☐ Glaucoma Suspect
- ☐ Strabismus
- ☐ Nystagmus
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Amblyopia
- ☐ Cataract
- ☐ Dry Eyes
- ☐ Severe Myopia

Social History

Do you drink alcohol?

- ☐ No
- ☐ Yes : Drinks/day:_____

Do you smoke?

- ☐ Never smoked
- ☐ Former smoker
- ☐ Current some day smoker
- ☐ Current every day smoker : packs/day:_____

Thank you. Please return these forms to our front desk.