Ritter Hagee Optometry New Patient History

Name:	DOB
Occupation:	Email Address:
Gender: Male Female Preferred Language:	
Race: Unknown DAmerican Indian or Atlantic Native DAsian DBlack or African American Native Hawaiian or Other Pacific Islander DOther Race DWhite	
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino	
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<u>Εγ</u>	<u>e History</u>
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	Glaucoma 🛛 Cataract
□ Patching □	Eye Surgery Retinal Hole
□ Strabismus □	Retinal Degeneration Nystagmus

- Inflammatory Disorder
- Eye Injury

Retinal Detachment

Glaucoma Suspect

Amblyopia

- Macular Degeneration
- Nystagmus
- Keratoconus
 - Other:_____

Medical History

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

Constitution:

Fatigue Syndrome

Developmental

Disabilities

Cancer

Sinusitis

□ Hearing Loss Laryngitis

Dry Mouth

Ear, Nose and Throat:

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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
- Π 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

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

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.