KUNG EYE
STATEN ISLAND OPHTHALMOLOGY ACADEMIC EYE CENTER

New Patient Forms

FIRST NAME:_____ M.I. _____ LAST NAME:_____

MARITAL STATUS: _____ GENDER: _____ S.S. #: _____ DOB: _____

MAILING ADDRESS: _____

HOME TEL #: _____ WORK #: _____ CELL #: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ TEL #: _____ RELATIONSHIP: _____

PRIMARY CARE PHYSICIAN/FAMILY DOCTOR NAME: _____ TEL #: _____

HOW DID YOU HEAR ABOUT US? (*CIRCLE*): ☐ **FRIENDS & FAMILY** ☐ **PRIMARY CARE PHYSICIAN** ☐ **OPTICAL**

☐ **INSURANCE PROVIDER LIST** ☐ **GOOGLE SEARCH/ONLINE** **OTHER: _____**

REFERRING DOCTOR/OPTICAL: _____ _____

ADDRESS: _____

WHAT LANGUAGES DO YOU SPEAK, OTHER THAN ENGLISH? _____

EMPLOYER COMPANY NAME: _____

WORK ADDRESS: _____

WORK TEL #: _____ OCCUPATION: _____

INSURANCE INFORMATION (*SUBSCRIBER INFO ON INSURANCE CARD*)

PRIMARY PLAN: _____ POLICY #: _____

GUARANTOR: _____ RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH: _____/_____/_____ S.S. #: _____-_____-_____

SECONDARY PLAN: _____ POLICY #: _____

GUARANTOR: _____ RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH: _____/_____/_____ S.S. #: _____-_____-_____

TERTIARY PLAN: _____ POLICY #: _____

GUARANTOR: _____ RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH: _____/_____/_____ S.S. #: _____-_____-_____

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Allergy Questionnaire

Have you ever suffered from any of the following symptoms?

Red Eyes	___ Yes	___ No
Itchy Eyes	___ Yes	___ No
Eyelid Swelling	___ Yes	___ No
Watery Eyes	___ Yes	___ No
Sandy, gritty sensation	___ Yes	___ No
Itchy Nose	___ Yes	___ No
Eyelid Swelling or Redness	___ Yes	___ No

If you have suffered from any of these previously mentioned symptoms, you may be suffering from allergies and we are now able to help you find the cause.

Kung Eye Center is excited to announce that we now have the capability to test you for your ocular allergies through a skin-scratch test. If you would like to be considered for this test, which is usually a covered service through your insurance carrier, please talk to your doctor today. By properly diagnosing your allergies, your Doctor can determine the proper treatment protocol for you.

Would you like to be tested for ocular allergies? _____ Yes _____ No

Signature _____

Patient Name (print) _____

Date _____

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Medical Health Questionnaire

PATIENT'S NAME:_____ TODAY'S DATE_____

MEDICAL HISTORY

HAVE YOU EVER HAD:

- ☐ HIGH BLOOD PRESSURE
- ☐ HEART PROBLEMS
- ☐ ARTHRITIS
- ☐ LUNG PROBLEMS
- ☐ STROKE
- ☐ THYROID PROBLEMS
- ☐ CANCER
- ☐ HIV
- ☐ DIABETES
- ☐ HIGH CHOLESTEROL
- ☐ ULCERS
- ☐ OTHER_____
  _____
  _____

HAVE YOU EVER HAD ANY SURGERY/PROCEDURE PERFORMED ON YOUR BODY? ☐ YES ☐ NO

IF YES, LIST ALL:_____

_____

DO YOU HAVE ANY ALLERGIES? ☐ YES ☐ NO

IF YES, LIST ALL (DRUGS, ALLERGENS, FOODS):_____

_____

EYE HEALTH HISTORY

HAVE YOU EVER HAD:

- ☐ DRY EYES
- ☐ GLAUCOMA
- ☐ CATARACTS
- ☐ MACULAR DEGENERATION
- ☐ RETINAL DETACHMENT
- ☐ KERATOCONUS
- ☐ OTHER_____

HAS ANY FAMILY MEMBER/BLOOD RELATIVE HAD:

- ☐ DRY EYES
- ☐ GLAUCOMA
- ☐ CATARACTS
- ☐ MACULAR DEGENERATION
- ☐ RETINAL DETACHMENT
- ☐ KERATOCONUS
- ☐ OTHER_____

HAVE YOU EVER HAD ANY SURGERY/PROCEDURE PERFORMED ON YOUR EYE(S)? ☐ YES ☐ NO

IF YES, LIST ALL:_____

_____

GENERAL HEALTH

HEIGHT _____ WEIGHT _____ AVERAGE BP _____

HAVE YOU EVER HAD THE FOLLOWING VACCINES: ☐PNEUMOCOCCAL ☐INFLUENZA/FLU

SOCIAL HISTORY

Do you smoke?	☐ Yes	☐ No	☐ Former smoker
Do you drink alcohol?	☐ Yes	☐ No	☐ Occasionally

MEDICATIONS

Are you currently taking any medications? ☐ Yes ☐ No

- ☐ Albuterol
- ☐ Aspirin
- ☐ Crestor (rosuvastatin) [for Cholesterol]
- ☐ Flomax [for Prostate]
- ☐ Hydrocodone
- ☐ Lipitor (atorvastatin) [for Cholesterol]
- ☐ Lisinopril [for High Blood Pressure]
- ☐ Maxivision Vitamins/Ocuvite [Eye Vitamins]
- ☐ Metformin [for Diabetes]
- ☐ Norvasc (amlodipine) [for High Blood Pressure]
- ☐ Plaquenil (hydroxychloroquine)
- ☐ Plavix (clopidogrel) [Blood Thinner]
- ☐ Synthroid (levothyroxine)
- ☐ Zocor (simvastatin) [for Cholesterol]
- ☐ Others:_____

_____

_____

Are you currently using any eye drops? ☐ Yes ☐ No

- ☐ Alphagan (brimondine)
- ☐ Combigan
- ☐ Cosopt (dorzolamide/timolol)
- ☐ Lumigan (bimatoprost)
- ☐ Patanol (olopatadine)
- ☐ PredForte (prednisolone)
- ☐ Restasis
- ☐ Simbrinza
- ☐ Tobradex
- ☐ Travatan Z
- ☐ Trusopt
- ☐ Xalatan (latanoprost)
- ☐ Xiidra
- ☐ Zaditor
- ☐ Others:_____

_____

_____