OPTX
rhode island

giulio diamante, md
& associates
exceptional eyecare

giulio diamante, md
board certified
BROWN
Alpert Medical School
clinical assistant
professor of ophthalmology

medical & eye history (new patient)

Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____

Thank you for choosing Giulio Diamante, MD and Associates as your eyecare specialists. To better serve you, we ask that you please answer the following questions:

1. Please describe the reason for your visit and any vision or eye complaints you may have: _____

_____

_____

2. Are you experiencing any of the symptoms below?

If yes, please check all that apply:

❒ blurred vision	❒ eyelid crusting	❒ foreign body sensation	❒ light sensitivity
❒ burning	❒ eye pain	❒ glare	❒ redness
❒ decreased vision	❒ eyestrain	❒ halos	❒ tearing
❒ discharge	❒ flashes of light	❒ headaches	
❒ double vision	❒ floaters	❒ itching	❒ other

please describe in detail: _____

_____

3. Do you currently wear glasses? ❒ yes ❒ no

Please describe the visual range of your glasses (near, distance, intermediate): _____

_____

4. If you do currently wear glasses, do you use more than one pair? ❒ yes ❒ no

If yes, please check all that apply:

❒ sunglasses ❒ reading glasses ❒ glasses for computer ❒ daytime driving

❒ safety glasses ❒ sports eyewear ❒ glasses for hobby ❒ night driving

5. Do you wear contact lenses? ❒ yes ❒ no

If yes, which brand and power do you wear? Right:_____

Left: _____

Are you experiencing difficulties with your contact lenses? ❒ yes ❒ no

If yes, please describe: _____

_____

6. Do you have visual difficulties with reading? ❒ yes ❒ no

If yes, please explain: _____

7. Do you work regularly with a computer or hand-held device? ❒ yes ❒ no

If yes, how many hours per day and per week? _____ hrs/day _____ hrs/week

8. Do you have any specific symptoms as a result of your computer use? ❒ yes ❒ no

If yes, please list: _____

continued on back ▸

9. What is your occupation and what are your visual demands at work? _____

_____

10. Eye history:

Have you ever experienced or been diagnosed with any of the following:

❒ amblyopia (lazy eye) ❒ dry eyes ❒ migraines

❒ cataract ❒ glaucoma ❒ retinal detachment

❒ diabetic eye disease ❒ macular degeneration ❒ other _____

please describe: _____

11. Have you ever had an eye injury? ❒ yes ❒ no

If yes, which eye and please describe: _____

_____

12. Have you ever had eye surgery? ❒ yes ❒ no

If yes, which eye, type of surgery, and approximate dates:

❒ right ❒ left _____

❒ right ❒ left _____

13. Do you take any ocular nutritional supplements? ❒ yes ❒ no

If yes, please list: _____

14. Are you currently using eye drops? ❒ yes ❒ no

If yes, please list which eye, name(s) of drops, and how often used:

❒ right ❒ left _____

❒ right ❒ left _____

15. Do you have any family history of eye problems? ❒ yes ❒ no

If yes, please check and list family relationship?

❒ blindness ❒ cataract ❒ glaucoma ❒ macular degeneration ❒ need for eyeglasses

❒ retinal detachment ❒ other: _____

relationship: _____

16. Are you being treated for any medical conditions? ❒ yes ❒ no

If yes, please check all that apply:

❒ arthritis ❒ asthma/copd ❒cancer ❒ diabetes ❒ heart disease ❒ high blood pressure

❒ stroke ❒ thyroid ❒ other: _____

_____

17. Please list all medications you are taking: _____

_____

_____

_____

18. Please list all major surgeries you have had: _____

_____

19. Do you have allergies to any medications? ❒ yes ❒ no

If yes, please describe: _____

_____

20. Do you have any other comments you feel may be relevant: _____

_____

_____

patient or legal guardian signature