Eye Consultants OF PENNSYLVANIA, PC

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New Patient Information Form

Please complete this form as clearly and completely as possible, and Bring It With You at the time of your appointment. PLEASE PRINT! This form will allow us to expedite your appointment. Thank you for your cooperation.

(Mr., Mrs., Miss, Ms.) Date: _____

First Name: _____Middle Initial: _____Last Name_____

Street Address: _____

City_____State_____Zip_____

Social Security Number: ____-_____-_____ Email: _____Sex: M____ F____

Telephone: Home(_____)_____-_____ Work(_____)_____-_____ Cell(_____)_____-_____

Age: _____ Date of Birth: _____/_____/_____ Occupation _____

Place of Employment: _____

Doctor	Name	Address
Referring Doctor		
Family Doctor		
Optometrist		

If the patient is a child, list name and address of the person financially responsible for the child's account below:

First Name: _____Middle Initial: _____Last Name_____

Street Address: _____

City_____State_____Zip_____

Social History:

Do you drive? Y / N Do you use illegal drugs? Y / N
Do you smoke? Y / N How much? _____ How long? _____Date stopped: _____
Do you drink? Y / N How much? _____

Eye Problems:

Cataracts: Y / N Corneal problems, dry eye: Y / N
Glaucoma: Y / N Eye injury: Y / N Describe: _____
Retinal disorders: Y / N Eye Surgery: Y / N What type? _____ When? _____
Do you wear glasses/contacts? Y / N Prescribed by: _____ When? _____

(**over**)

Medical Information/History

Many diseases of the body can affect the eyes. Please check box/boxes below if you have or had any of the following medical conditions. This information is needed to assure the best possible treatment. All information is confidential.

I Have/Had	n/a	Condition	I Have/Had	n/a	Condition
		Diabetes **(Onset year?)**			Arthritis
		Thyroid, Metabolism			Liver Problems
		High Blood Pressure			Stomach, Ulcers, GERD
		Stroke, Carotid Disease			Colitis, Chronic Diarrhea
		Heart Disease, Attack			Hepatitis **(Type?)**
		Chest Pain, Angina			Kidney Disease, Stones
		Cholesterol			Herpes, Genital/Cold Sores
		Asthma, Emphysema, COPD			Sexually Transmitted Diseases
		Neurological Problems			Auto Immune Diseases
		Sleep Apnea			HIV Exposure, Aids
		Hearing Problems			Shingles, Chicken Pox
		Sinus Problems			Skin Disease
		Headaches, Migraines			Anemia, Blood Disorder
		Epilepsy, Seizures			Cancer **(Type?)**
		Muscular-Skeletal Problems/Back Issues			Psychological Probs. Depression, Anxiety

Other (Not listed above)

Previous Surgeries:

Medication Allergies: (Please include Reaction)

Food / Other Allergies: (Please include Reaction)

Latex or Rubber Allergy? Y / N

Please list Below **ALL** the medications that you are currently taking **or Bring A List** to your first appointment.

Medication, Eye Drops & Vitamins	How Often

I am now, or have taken in the past:	
	Cardura / Doxazosin
	Flomax / Tamsulosin
	Hytrin / Terazosin
	Rapaflo / Silodosin
	Uroxatral / Alfuzosin
	Amiodarone
	Bisphosphonates (Osteoporosis Rx)
	Ethambutol
	Fingolimod (CME)
	Interferon
	Tamoxifen
	Chloroquine/Plaquenil

DO NOT MAIL THIS FORM