Eye Consultants OF PENNSYLVANIA, PC

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570.622.9285 Fax

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Blandon, PA 19510
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610.926.8160 Fax

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Lebanon, PA 17042
717.272.2161
717.270.0301 Fax

TOLL FREE: 1-800-762-7132 **Website: EyeConsultantsOfPA.com** **E-mail: ecop@ecop.us**

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. Please remember to bring your current insurance cards to all appointments! 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: Cell (_____) _____-_____ Work (_____) _____-_____ Home (_____) _____-_____

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

Place of Employment: _____

Local Pharmacy (Name / Location) _____ Mail Order _____

Doctor	Name	Address
Referring Doctor		
Family Doctor		
Optometrist		

Please complete the following information of the person financially responsible for this account if not the same as the patient listed above.

First Name: _____ Middle Initial: _____ Last Name _____

Date of Birth: _____/_____/_____ Relationship to Patient _____

Street Address: _____

City _____ State _____ Zip _____

Social History:

Do you drive? ☐ Yes ☐ No Do you smoke, or have you ever smoked? ☐ Yes ☐ No

Do you use illegal drugs? ☐ Yes ☐ No Do you drink? ☐ Yes ☐ No How much? _____

Eye Problems:

Cataracts: ☐ Yes ☐ No Corneal problems, dry eye: ☐ Yes ☐ No

Glaucoma: ☐ Yes ☐ No Eye injury: ☐ Yes ☐ No Describe: _____

Retinal disorders: ☐ Yes ☐ No Eye Surgery: ☐ Yes ☐ No What type? _____ When? _____

Do you wear glasses/contacts? ☐ Yes ☐ No 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 / I Had	n/a	Condition
☐	☐	Chest Pain, Angina
☐	☐	Anxiety, Depression, Other Psychological Issues
☐	☐	Arthritis
☐	☐	Asthma, Emphysema, COPD
☐	☐	Heart Disease, Attack, Atrial Fibrillation
☐	☐	Anemia, Blood Disorder
☐	☐	Blood Clots
☐	☐	Cancer **(Type?)**
☐	☐	Stroke, Carotid Disease
☐	☐	Diabetes **(Onset year?)**
☐	☐	Cholesterol
☐	☐	Stomach, Ulcers, GERD
☐	☐	Headaches, Migraines
☐	☐	Liver Problems, Hepatitis **(Type?)**
☐	☐	High Blood Pressure

I Have / I Had	n/a	Condition
☐	☐	Kidney Disease, Stones
☐	☐	Seizure Disorder, Epilepsy
☐	☐	Thyroid, Metabolism
☐	☐	Neurological Problems
☐	☐	Sleep Apnea
☐	☐	Hearing Problems
☐	☐	Sinus Problems
☐	☐	Muscular-Skeletal Problems/Back Issues
☐	☐	Colitis, Chronic Diarrhea, IBS
☐	☐	Herpes - Genital or Common Cold Sores
☐	☐	Sexually Transmitted Diseases
☐	☐	Auto Immune Diseases
☐	☐	HIV Exposure, Aids
☐	☐	Shingles, Chicken Pox
☐	☐	Skin Disease

Other (Not listed above)

Previous Surgeries:

Medication Allergies: (Please include Reaction)

Seasonal / Food / Other Allergies: (Please include Reaction)

Latex or Rubber Allergy? ☐ Yes ☐ No

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
List below any medications you self-inject at home:	

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