HARRISBURG EYE·CARE

CONFIDENTIAL PATIENT INFORMATION

Name _____ Today's Date _____

Last First MI

Date of birth _____ Social Security Number_____

Address _____

City _____ State _____ Zip _____

E-mail _____ Home Phone _____

Cell Phone _____ Work Phone _____

Are you: ▫ Married ▫ Widowed ▫ Single ▫ Minor ▫ Separated ▫ Divorced

Employer / School _____ Occupation _____

Emergency Contact _____ Phone _____

Do you prefer to receive calls via : ▫ Home ▫ Work ▫ Cell ▫ Email ▫ No preference

HOW DID YOU HEAR ABOUT OUR OFFICE?

▫ Newspaper ▫ Direct Mail ▫ Drove by/Saw Sign ▫ Insurance

▫ Physician ▫ Internet ▫ Word of Mouth - Who may we thank?_____

PERSONAL HEALTH HISTORY

Date of last eye exam _____ Name of last eye doctor _____

Date of last physician visit _____ Name of physician _____

Please list any medications you take (prescription or over the counter)_____

_____

Are you allergic to any medications?: ▫ Y ▫ N If yes, please list:_____

Any other allergies? ▫ Y ▫ N If yes, please list:_____

Please check any of the following that apply specifically **to you and your** eye health.

Headaches	▫	Glare/Light Sensitivity	▫
Tired Eyes	▫	Burning Eyes	▫
Dry Eyes	▫	Excessive Tearing/Watering	▫
Eye Pain or Soreness	▫	Double Vision	▫
Itching Eyes	▫	Redness of Eye(s)	▫
Sandy or Gritty Feeling in Eye(s)	▫	Blurred Vision	▫
Floaters	▫	Cataracts	▫
Glaucoma	▫	Macular Degeneration	▫
Other eye disease	▫	Previous Eye Surgery	▫

GLASSES HISTORY

Do you currently wear glasses? ▫ Y ▫ N ▫Full time ▫Part time ▫Distance ▫Reading

Do you wear sunglasses? ▫ Y ▫ N If yes, are they prescription? ▫ Y ▫ N

Do you use a computer? ▫ Y ▫ N How many hours per day? _____

CONTACT LENS HISTORY

Do you currently wear contact lenses? ▫ Y ▫ N

Current brand of contacts? _____

How many hours per day do you wear your contacts? _____ How often do you sleep in your contacts? _____

Any problems with your present contacts? ▫ Y ▫ N If yes, what? _____

CHECK YES OR NO FOR THE EACH OF THE FOLLOWING REGARDING YOUR HEALTH HISTORY:

	YES	NO	DETAILS
General (fever, weight loss/gain)	▫	▫	_____
Ear/Nose/Throat (hearing loss, stuffy nose, cough)	▫	▫	_____
Cardiovascular (high BP, irregular heartbeat)	▫	▫	_____
Respiratory (congestion, wheezing, short of breath)	▫	▫	_____
Gastrointestinal (diarrhea, ulcers, constipation)	▫	▫	_____
Kidney/Bladder/Genital (painful/frequent urination)	▫	▫	_____
Muscles/Bones/Joints (arthritis, stiffness)	▫	▫	_____
Skin (warts, growths, rash)	▫	▫	_____
Neurological (numbness, headache, seizures)	▫	▫	_____
Psychiatric (anxiety, depression, insomnia)	▫	▫	_____
Endocrine (diabetes, hypothyroid, hyperthyroid)	▫	▫	_____
Blood/Lymph (bleeding, high cholesterol)	▫	▫	_____
Allergic/Immunologic (swelling, itching, lupus)	▫	▫	_____
Females: Are you pregnant or nursing?	▫	▫	_____

FAMILY HEALTH HISTORY

Does anyone in your family (mother, father, grandparent, siblings) have any of these conditions? Check all that apply and explain below

Cataracts	▫	Diabetes	▫
Glaucoma	▫	High Blood Pressure	▫
Macular Degeneration	▫	Heart Disease	▫
Other eye disease?	▫	Cancer	▫

_____

_____

SOCIAL HISTORY

Do you drink alcohol? ▫ Y ▫ N If yes, how much? _____

Do you smoke or use tobacco? ▫ Y ▫ N If yes, how much? _____

Do you use recreational drugs? ▫ Y ▫ N If yes, what type? _____

What hobbies or sports do you participate in? _____

Are you planning on getting new glasses today? ▫ Yes ▫ No ▫ Maybe

Are you planning on getting new contacts today? ▫ Yes ▫ No

Are you interested in LASIK surgery? ▫ Yes ▫ No

_____ _____

Patient's Signature Date

PLEASE DO NOT WRITE BELOW THIS LINE

I *have reviewed this history with the patient.*

_____ _____ _____

Doctor's Signature / Date Doctor's Signature / Date Doctor's Signature / Date