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

Race/Ethnicity: □ Caucasian □ African Amer. □ Native Amer. □ Asian □ Pacific Isl. □ Hispanic □ No Answer

Preferred Language: _____

Employer / School _____ Occupation _____

Emergency Contact _____ Phone _____

Preferred contact: □ Home □ Work □ Cell □ Email □ No preference

If you were referred to us, 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

		Who			Who
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