Bucks County Division
Tri-County Eye
Century Eye Care
Eye Associates of Bucks County

Patient History Form

First Name: ______________________ Last Name: ______________________ Sex: M / F

Address: ____

Marital Status: ________ Date of Birth (DOB): ________ Race: ____________ Ethnicity: ____________

Email address: ____________________ Home: ______________ Cell: ______________

Emergency Contact: ____________________ Phone: ____________ Relationship: __________

Primary Care Physician: ____________________ Phone: ____________________

Referred by (if other than PCP): ____________________ Phone: ____________________

Pharmacy Name/Address/Phone: ____

If you are a new patient, date of last eye exam: ____________________

Reason for today's visit (symptoms): ____

List any significant eye conditions and surgeries with dates (cataracts, macular degeneration, diabetic retinopathy, glaucoma, injuries to the eye, lasers, injections, lazy eye, crossed eyes, etc.):

____

MEDICAL HISTORY – Have you ever had any problems in the following areas?

☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Anemia
☐ Yes	☐ No	Degenerative arthritis	☐ Yes	☐ No	Hiatal hernia	☐ Yes	☐ No	Leukemia
☐ Yes	☐ No	Rheumatoid arthritis	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No	Sickle cell disease
☐ Yes	☐ No	Alzheimer's Disease	☐ Yes	☐ No	Skin disease	☐ Yes	☐ No	Thyroid problems
☐ Yes	☐ No	Migraines	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No	Emphysema
☐ Yes	☐ No	Convulsions/seizures	☐ Yes	☐ No	Pregnant	☐ Yes	☐ No	Tuberculosis
☐ Yes	☐ No	Stroke/paralysis	☐ Yes	☐ No	Congestive heart failure	☐ Yes	☐ No	Sarcoidosis
☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No	Immune problems
☐ Yes	☐ No	Multiple sclerosis	☐ Yes	☐ No	Heart attack	☐ Yes	☐ No	High cholesterol
☐ Yes	☐ No	Schizophrenia	☐ Yes	☐ No	Irregular/fast heartbeat	☐ Yes	☐ No	Cancer - please specify
☐ Yes	☐ No	Lupus	☐ Yes	☐ No	High blood pressure			____________

List any surgeries with dates: ____

FAMILY AND SOCIAL HISTORY:

Eye Diseases	Relationship to patient	**Medical Diseases**	Relationship to patient	**Medical Diseases**	Relationship to patient
☐ Amblyopia (lazy eye)		☐ Arthritis		☐ Respiratory disease	
☐ Blindness		☐ Asthma		☐ Stroke	
☐ Cataracts		☐ Cancer		☐ Thyroid disease	
☐ Corneal disease		☐ Circulatory disorders		☐ Tuberculosis	
☐ Glaucoma		☐ Diabetes		☐ Other	
☐ Macular Degeneration		☐ Heart attack			
☐ Retinal detachment		☐ Heart disease			
☐ Retinal disorders		☐ High blood pressure			
☐ Strabismus		☐ Kidney disease			

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Do you smoke or use tobacco? □ Never smoked/used tobacco □ Former smoker □ Unknown
□ Current some day smoker □ Current every day smoker □ Current heavy smoker

Have you fallen in the last year? □ Yes □ No

If yes, how many falls in the last year? _____ Did any fall result in an injury? □ Yes □ No

REVIEW OF SYSTEMS - Do you presently have any problems in the following areas? (Please check Yes or No)

CONSTITUTIONAL SYMPTOMS			GASTROINTESTINAL (Stomach/Intestines)		
□ Yes	□ No	Fatigue	□ Yes	□ No	Constipation
□ Yes	□ No	Fever	□ Yes	□ No	Diarrhea
□ Yes	□ No	Night sweats	□ Yes	□ No	Vomiting
Other			Other		
HEENT (Head, Ears, Nose and Throat)			**PSYCHIATRIC**		
□ Yes	□ No	Hearing loss	□ Yes	□ No	Emotional changes
Other			Other		
RESPIRATORY (Lungs/Breathing)			**NEUROLOGICAL**		
□ Yes	□ No	Cough	□ Yes	□ No	Dizziness
□ Yes	□ No	Wheezing	□ Yes	□ No	Headaches
Other			Other		
CARDIOVASCULAR			**HEMATOLOGIC/LYMPHATIC**		
□ Yes	□ No	Chest pressure or discomfort	□ Yes	□ No	Bleeding
□ Yes	□ No	Irregular heartbeat/palpitations	□ Yes	□ No	Bruising
Other			Other		
GENITOURINARY (Genitals/Kidney/Bladder)			**ALLERGIC/IMMUNOLOGIC**		
□ Yes	□ No	Dysuria (painful urination)	□ Yes	□ No	Environmental allergies
□ Yes	□ No	Hematuria (blood in urine)	□ Yes	□ No	Food allergies
Other			Other		
METABOLIC/ENDROCRINE			**MUSCULOSKELETAL**		
□ Yes	□ No	Cold intolerance	□ Yes	□ No	Arthralgia (joint pain)
□ Yes	□ No	Heat intolerance	□ Yes	□ No	Gait disturbance
□ Yes	□ No	Polydipsia (excessive thirst)	□ Yes	□ No	Joint swelling
□ Yes	□ No	Polyphagia (excessive hunger)	□ Yes	□ No	Muscle weakness
□ Yes	□ No	Polyuria (frequent urination)			
Other			Other		
INTEGUMENTARY (Skin)					
□ Yes	□ No	Rash			
Other					

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MEDICATIONS AND ALLERGIES:

List all EYE medications you take (prescription and over-the-counter). Attach a list if necessary.

Name of Eye Medication	Dosage	Start Date

List all OTHER (non-eye) medications you take (prescription and over-the-counter). Attach a list if necessary.

Name of Medication	Dosage	Start Date

List all known allergies.
□ Check here if you have no known allergies

Allergen	Reaction	Severity