Eye Associates OF BUCKS COUNTY

Patient History Form

Today's Date:_____

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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Patient Name: _____ DOB: ____/____/_____

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