PENNWOOD OPHTHALMIC ASSOCIATES, PC

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NEW PATIENT INFORMATION

LAST: _____FIRST:_____ M.I.: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____

WK PHONE: _____CELL PHONE: _____

SEX: _____BIRTHDATE:_____SSN:_____

RACE: (circle one) WHITE BLACK/AFRICAN AMERICAN HISPANIC OTHER _____

MARTIAL STATUS: _____ SPOUSE'S NAME: _____

SPOUSE'S BIRTHDATE: _____SSN: _____

NAME OF PHARMACY: _____PHONE#:_____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

FAMILY DOCTOR: _____ REFERRING DOCTOR: _____

****************************MUST BE COMPLETED BELOW ***************************

POLICYHOLDER'S NAME: _____ DATE OF BIRTH: _____

POLICYHOLDER'S SSN: _____ EMPLOYER: _____

" I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO PENNWOOD OPHTHALMIC ASSOICATES, PC FOR ANY SERVICES FURNISHED ME BY THE ABOVE DOCTORS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY AND ITS AGENTS AND INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES."

PATIENT'S SIGNATURE: _____ DATE: _____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING EYE PROBLEMS RECENTLY:

	YES	NO		YES	NO
FLOATERS OR SPOT	____	____	HEADACHES	____	____
FLASHING LIGHTS	____	____	EYE STRAIN	____	____
JAGGED LINES	____	____	DOUBLE VISION	____	____
BLURRY NEAR VISION	____	____	BLIND SPOTS	____	____
BLURRY DISTANCE VISION	____	____	BURNING	____	____
SUDDEN LOSS OF VISION	____	____	MATTING/CRUSTING	____	____
HALOS AROUND LIGHTS	____	____	TEARING	____	____
PROBLEMS WITH GLARE	____	____	REDNESS	____	____
POOR SIDE VISION	____	____	DRYNESS	____	____
FAINTING/DIZZINESS	____	____	GRITTY FEELING	____	____
SENSITIVITY TO LIGHT	____	____	SEASONAL ALLERGIES	____	____
ITCHING	____	____			

ANY FAMILY MEMBER WITH THE FOLLOWING HEALTH CONDITIONS:

	YES	NO		YES	NO
CATARACTS	____	____	HEART DISEASE	____	____
GLAUCOMA	____	____	DIABETES	____	____
MACULAR DEGENERATION	____	____	CANCER	____	____
BLINDNESS	____	____	OTHER	____	____
LAZY EYE	____	____			

SOCIAL HISTORY:

	YES	NO
DO YOU DRIVE? ……	____	____
DO YOU WEAR GLASSES? ……	____	____
ARE YOU PREGNANT? ……	____	____
ARE YOU A FORMER OR CURRENT SMOKER? ……	____	____
DO YOU DRINK MORE THAN 4 ALCOHOLIC DRINKS PER WEEK? ……	____	____

WHAT IS YOUR OCCUPATION? _____

	YES	NO
ARE YOU A PREVIOUS OR CURRENT CONTACT LENS WEARER?		

WHAT KIND? _____ NAME OF SOLUTION? _____

	YES	NO
ARE YOU INTERESTED IN CONTACTS?		
ARE YOU HAVING ANY PROBLEMS WITH YOUR CURRENTS CONTACTS		

PLEASE EXPLAIN: _____

DO YOU ……

	YES	NO
WORK ON A COMPUTER FOR LONG PERIODS OF TIME?	____	____
HAVE MORE THAN ONE PAIR OF GLASSES?	____	____
HAVE GLASSES THAT ARE UNCOMFORTABLE?	____	____
WANT INFORMATION ON THINNER/LIGHTER LENSES?	____	____
WEAR BIFOCALS?	____	____
SPEND TIME OUTDOOR?	____	____
HAVE PRESCRIPTION SUNGLASSES?	____	____
EXPERIENCE GLARE WITH NIGHT DRIVING?	____	____
PLAY THE PIANO OR ORGAN?	____	____

PARTICIPATE IN ANY SPORTS OR HOBBIES? IF SO WHAT _____

YOUR EYE HISTORY – DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO		YES	NO
GLAUCOMA	____	____	EYE INJURY	____	____
MACULAR DEGENERATION	____	____	EYE INFECTION	____	____
CATARACTS	____	____	EYE SURGERY	____	____
RETINAL DISORDER	____	____	EYE TUMOR	____	____
CORNEAL DISEASE	____	____	LAZY EYE	____	____

YOUR MEDICAL HISTORY – DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
DIABETES	____	____	ARTHRITIS	____	____
HIGH BLOOD PRESSURE	____	____	CANCER	____	____
HEART DISEASE	____	____	KIDNEY DISEASE	____	____
LUNG DISEASE	____	____	THYROID DISEASE	____	____
ASTHMA	____	____	SEIZURE DISORDER	____	____
DEPRESSION	____	____	STROKE	____	____
BLEEDING PROBLEMS	____	____	ANXIETY	____	____
SKIN DISORDER/RASH	____	____	MIGRAINES	____	____
HIGH CHOLESTROL	____	____	HIV	____	____

PLEASE LIST ANY ADDITIONAL HEALTH PROBLEMS AND PAST SURGERIES:

_____

_____

_____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS:

_____

_____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING INCLUDE DOSAGES AND HOW OFTEN THE MEDICATION IS TAKEN. PLEASE INCLUDE ANY EYE DROPS AND/OR OVER THE COUNTER MEDICATIONS (ASPIRIN, MULTI VITAMINS, ETC) OR ATTACH YOUR OWN LIST

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