PENNWOOD OPHTHALMIC ASSOCIATES, PC

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NEW PATIENT INFORMATION

CHILD'S INFORMATION:

LAST: _____FIRST:_____ M.I.: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____

SEX: _____BIRTHDATE:_____SSN:_____

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

PHARMACY: _____

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

POLICYHOLDER'S NAME _____ POLICY# _____

DATE OF BIRTH: _____ SSN: _____

POLICYHOLDER'S ADDRESS: _____

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MOTHER'S NAME: _____ SSN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: _____ WORK #: _____ CELL #: _____

****

FATHER'S NAME: _____ SSN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME#: _____ WORK#: _____ CELL #: _____

PARENT'S SIGNATURE: _____

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? _____

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

WHAT KIND? _____ NAME OF SOLUTION? _____

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

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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