Eye Consultants OF PENNSYLVANIA, PC

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570.622.9285 Fax

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Blandon, PA 19510
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Lebanon, PA 17042
717.272.2161
717.270.0301 Fax

TOLL FREE: 1-800-762-7132 **Website: EyeConsultantsOfPA.com** **E-mail: ecop@ecop.us**

New Patient Information Form

Please complete this form as clearly and completely as possible, and Bring It With You at the time of your appointment. PLEASE PRINT! This form will allow us to expedite your appointment. Thank you for your cooperation.

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Date: ____________________

First Name: ____________________ Middle Initial: ________ Last Name ____________________

Street Address: ____________________

City ____________________ State ____________ Zip ____________

Social Security Number: ____-_____-_____ Email: ____________________ Sex: M____ F____

Telephone: Cell (_______) _______-__________ Work (_______) _______-__________ Home (_______) _______-__________

Age: ___________ Date of Birth: _____/______/_______ Occupation ____________________

Place of Employment: ____________________

Local Pharmacy (Name / Location) ____________________ Mail Order ____________________

Doctor	Name	Address
Referring Doctor		
Family Doctor		
Optometrist		

Please complete the following information of the person financially responsible for this account if not the same as the patient listed above.

First Name: ____________________ Middle Initial: ________ Last Name ____________________

Date of Birth: _____/______/_______ Relationship to Patient ____________________

Street Address: ____________________

City ____________________ State ____________ Zip ____________

Social History:

Do you drive? ☐ Yes ☐ No Do you smoke, or have you ever smoked? ☐ Yes ☐ No

Do you use illegal drugs? ☐ Yes ☐ No Do you drink? ☐ Yes ☐ No How much? ____________________

Eye Problems:

Cataracts: ☐ Yes ☐ No Corneal problems, dry eye: ☐ Yes ☐ No

Glaucoma: ☐ Yes ☐ No Eye injury: ☐ Yes ☐ No Describe: ____________________

Retinal disorders: ☐ Yes ☐ No Eye Surgery: ☐ Yes ☐ No What type? ____________________ When? ____________

Do you wear glasses/contacts? ☐ Yes ☐ No Prescribed by: ____________________ When? ____________

(over)

Medical Information/History

Many diseases of the body can affect the eyes. Please check box/boxes below if you have or had any of the following medical conditions.This information is needed to assure the best possible treatment. All information is confidential.

I Have / I Had	n/a	Condition
☐	☐	Chest Pain, Angina
☐	☐	Anxiety, Depression, Other Psychological Issues
☐	☐	Arthritis
☐	☐	Asthma, Emphysema, COPD
☐	☐	Heart Disease, Attack, Atrial Fibrillation
☐	☐	Anemia, Blood Disorder
☐	☐	Blood Clots
☐	☐	Cancer **(Type?)**
☐	☐	Stroke, Carotid Disease
☐	☐	Diabetes **(Onset year?)**
☐	☐	Cholesterol
☐	☐	Stomach, Ulcers, GERD
☐	☐	Headaches, Migraines
☐	☐	Liver Problems, Hepatitis **(Type?)**
☐	☐	High Blood Pressure

I Have / I Had	n/a	Condition
☐	☐	Kidney Disease, Stones
☐	☐	Seizure Disorder, Epilepsy
☐	☐	Thyroid, Metabolism
☐	☐	Neurological Problems
☐	☐	Sleep Apnea
☐	☐	Hearing Problems
☐	☐	Sinus Problems
☐	☐	Muscular-Skeletal Problems/Back Issues
☐	☐	Colitis, Chronic Diarrhea, IBS
☐	☐	Herpes - Genital or Common Cold Sores
☐	☐	Sexually Transmitted Diseases
☐	☐	Auto Immune Diseases
☐	☐	HIV Exposure, Aids
☐	☐	Shingles, Chicken Pox
☐	☐	Skin Disease

Other (Not listed above)

Previous Surgeries:

Medication Allergies: (Please include Reaction)

Seasonal / Food / Other Allergies: (Please include Reaction)

Latex or Rubber Allergy? ☐ Yes ☐ No

Please list Below ALL the medications that you are currently taking or Bring A List to your first appointment:

Medication, Eye Drops & Vitamins	How Often

I am now, or have taken in the past:

- ☐ Cardura / Doxazosin
- ☐ Flomax / Tamsulosin
- ☐ Hytrin / Terazosin
- ☐ Rapaflo / Silodosin
- ☐ Uroxatral / Alfuzosin
- ☐ Amiodarone
- ☐ Bisphosphonates (Osteoporosis Rx)
- ☐ Ethambutol
- ☐ Fingolimod (CME)
- ☐ Interferon
- ☐ Tamoxifen
- ☐ Chloroquine/Plaquenil

DO NOT MAIL THIS FORM