EYE SURGICAL-MEDICAL ASSOCIATES

8118 Bustleton Avenue
Philadelphia, PA 19152
Phone (215) 342-8118

Date: ______________________ **DOB** ______/______/________ **Age** _____ **SSN** ______-______-_________

Name _________________________ _________________________ _____ **Martial Status** ☐M ☐S ☐D ☐W ☐ Other

Last *First* *M.*

Address ____ **Primary Language** ☐English ☐Spanish ☐Russian ☐ Other____________________

City/St ________________________________ **Zip** _________ **Special Need** ☐Hearing Impaired ☐Translator☐Wheelchair

Preferred Contact

Home # (_____) ______-_______________ ☐ **Race** ☐White ☐African American ☐Asian ☐Other ☐Decline to Answer

Cell # (_____) ______-_______________ ☐ **Ethnicity** ☐Hispanic or Latino ☐Non-Hispanic or Latino☐Decline

Other # (_____) ______-_______________ ☐ Name: _____________________

Email: ______________________________ **Reason for visit today?**____

Referring Doctor: ____ **Phone:** _______________________

(Please list any/all physicians who are involved with your medical care and would want us to send letters)

Primary Physician:____ **Phone:** _______________________

Endocrinologist: ____ **Phone:** _______________________

Cardiologist: ____ **Phone:** _______________________

Other: ____ **Phone:** _______________________

List of previous surgeries with dates

______________________________ **Date:** _____________ **/** ________________________________ **Date:** _______________

______________________________ **Date:** _____________ **/** ________________________________ **Date:** _______________

______________________________ **Date:** _____________ **/** ________________________________ **Date:** _______________

Social History

History of Tobacco use ☐**Yes** ☐**No** **Year Quit** ________

Current Tobacco use ☐**Yes -** ☐ **Daily #**______per day/ #_____years ☐**Occasional #**______per day ☐**No**

Do you drink alcohol? ☐**Yes** ☐**No** ☐**Formally**

How many/often **#**________ ☐**Daily**☐**Weekly** ☐**Monthly**

Do you exercise? ☐**Yes** ☐**No**

How often **#** ________ **per week**

Pharmacy/Location: ____ **Phone:**___________________________

Allergies: Please list below the allergy and the known reaction ____

____

Medications: (List all current medications/prescriptions including vitamins, over-the-counter, and eye drops complete with dosages and duration)

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

**** If you have a current list, our front desk representatives will be happy to make a copy for your file ****

Do you wear glasses?	**☐Yes**	**☐No**	**Are you bothered by glare from:**		
Do you wear contacts lenses?	**☐Yes**	**☐No**	**Overhead lighting?**	**☐Yes**	**☐No**
Are you interested in contact lenses?	**☐Yes**	**☐No**	**A computer screen?**	**☐Yes**	**☐No**
Are you interested in refractive surgery?	**☐Yes**	**☐No**	**Oncoming headlights at night?**	**☐Yes**	**☐No**
Do you perform fine or close-up work?	**☐Yes**	**☐No**	**Are you sensitive in bright sunlight?**	**☐Yes**	**☐No**
Are you outdoors all or part of the time?	**☐Yes**	**☐No**			

Ocular History

Age-related macular degeneration	**☐Yes**	**☐No**	**Injury to the eye region**	**☐Yes**	**☐No**
Amblyopia (Lazy eye)	**☐Yes**	**☐No**	**Keratoconus**	**☐Yes**	**☐No**
Blindness-one eye	**☐Yes**	**☐No**	**Retinopathy**	**☐Yes**	**☐No**
Blindness-both eyes	**☐Yes**	**☐No**	**Strabismus (crossed eyes)**	**☐Yes**	**☐No**
Cataracts	**☐Yes**	**☐No**	**Tear Film insufficiency (dry eyes)**	**☐Yes**	**☐No**
Glaucoma	**☐Yes**	**☐No**	**Other** ______________________		
History of refractive surgery (Lasik/PRK)	**☐Yes**	**☐No**			

Patient's Past Medical History

Allergies	onset ________	☐Yes	☐No	**Angina**	onset________	☐Yes	☐No
Anxiety	onset ________	☐Yes	☐No	**Arthritis**	onset________	☐Yes	☐No
Asthma	onset ________	☐Yes	☐No	**Atrial Fibrillation**	onset________	☐Yes	☐No
Blood clots	onset ________	☐Yes	☐No	**Cancer -**__________	onset________	☐Yes	☐No
Cardiac arrythmia	onset________	☐Yes	☐No	**COPD**	onset________	☐Yes	☐No
Coronary artery disease	onset________	☐Yes	☐No	**Depression**	onset________	☐Yes	☐No
Diabetes	onset________	☐Yes	☐No	**Elevated lipids**	onset________	☐Yes	☐No
Last sugar ______	date__________			**Gallbladder disease**	onset________	☐Yes	☐No
Last A1C ______	date__________			**GERD**	onset________	☐Yes	☐No
Headache, migraine	onset________	☐Yes	☐No	**Heart Disease**	onset________	☐Yes	☐No
Hepatitis/liver disease	onset________	☐Yes	☐No	**Hypertension**	onset________	☐Yes	☐No
Irritable bowel	onset________	☐Yes	☐No	**Myocardial infarction**	onset________	☐Yes	☐No
Osteoporosis	onset________	☐Yes	☐No	**Renal disease**	onset________	☐Yes	☐No
Seizure disorder	onset________	☐Yes	☐No	**Stroke**	onset________	☐Yes	☐No
Thyroid disease	onset________	☐Yes	☐No				

Name ____ Date ______/_______/___________

Family Health History (mark Yes or No. If Yes, list which family member including mother, father, brother, sister, maternal/paternal grandmother or grandfather)

Condition	Yes	No	Condition	Yes	No
Amblyopia (lazy eye)	☐Yes ___________	☐No	**Strabismus (cross eyes)**	☐Yes ___________	☐No
Blindness	☐Yes ___________	☐No	**Arthritis**	☐Yes ___________	☐No
Cataract	☐Yes ___________	☐No	**Cancer**	☐Yes ___________	☐No
Macular Degeneration	☐Yes ___________	☐No	**Diabetes mellitus**	☐Yes ___________	☐No
Glaucoma	☐Yes ___________	☐No	**Hypertension**	☐Yes ___________	☐No
Retinal disorder	☐Yes ___________	☐No	**Cardiovascular disease**	☐Yes ___________	☐No
Stroke	☐Yes ___________	☐No			

Review of Systems

	Yes	No
Constitutional-		
Change in appetite	☐	☐
Chills/rigors	☐	☐
Fever	☐	☐
Other:________________________	☐	☐
Cardiovascular-		
Chest pain	☐	☐
Irregular heartbeat	☐	☐
Other:________________________	☐	☐
Ears/Nose/Mouth/Throat-		
Hearing loss	☐	☐
Vertigo	☐	☐
Other:________________________	☐	☐
Endocrine-		
Diabetes Type I	☐	☐
Diabetes Type II	☐	☐
Thyroid/Other Glands	☐	☐
Other: ________________________	☐	☐
Gastrointestinal-		
Crohn's Disease	☐	☐
Hepatitis _________	☐	☐
Ulcer / Reflux	☐	☐
Other:________________________	☐	☐
Allergic / Immunologic		
Eczema	☐	☐
Hives	☐	☐
Lupus	☐	☐
Organ transplant	☐	☐
Other:________________________	☐	☐
Integumentary (skin)-		
Skin Cancer	☐	☐
Skin disease	☐	☐
Herpes Zoster/Shingles	☐	☐
Other:________________________	☐	☐

	Yes	No
Musculoskeletal-		
Joint/Muscle Pain	☐	☐
Osteo Arthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Other:________________________	☐	☐
Lymphatic – Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Other:________________________	☐	☐
Neurological-		
Headaches	☐	☐
Mirgraines	☐	☐
Seizures	☐	☐
Other:________________________	☐	☐
Psychiatric-		
Depression	☐	☐
Anxiety	☐	☐
Panic Disorder	☐	☐
Other:________________________	☐	☐
Respiratory-		
Asthma	☐	☐
Cough	☐	☐
Wheezing	☐	☐
Shortness of breath	☐	☐
Other:________________________	☐	☐
Vascular-		
Thrombophlebitis	☐	☐
Varicose veins	☐	☐
Other:________________________	☐	☐

Print Name ____ Todays Date: _________/_________/___________

Sign Name ____