

Instructions For Completing Welcome to Professional Eye Associates Form

This form can be completed either by printing it out and filling it out by hand or by clicking from field to field and typing in the blank shaded boxes and clicking on the check boxes where designated and then printing it.

After completing form, please Bring it with you to your first appointment

Please call 570-839-2221 and ask for Sandi if you have any questions completing this form.

Thank you.

Name: _____

Date: _____

Eye Health History

Check **Yes** or **No** to indicate if you currently have the following:

Date of last eye exam ____/____/____	Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Medical Doctor _____	Bloodshot Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last health exam ____/____/____	Blurred Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear eyeglasses <input type="checkbox"/> Yes <input type="checkbox"/> No	Distance		Itching Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> All the time <input type="checkbox"/> Occasionally	Blurred Vision Near	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> TV	Burning Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type: _____ Hrs/Day _____	Color Vision Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Vision Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe any problems you have with your Contact Lenses	Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Discharge from Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Temp Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Twitching Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Fainting Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Watering Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical Health History

Check **Yes** or **No** to indicate if you have had the following:

Check **Yes** or **No** to indicate if an immediate family member (blood relative) has had any of the following:

Yourself		Family Member		Yourself		Family Member	
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer (Type)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor Color Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes (Type)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Drug Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Turned Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco Use	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Female Patients Only Please:

Are you pregnant? Yes No

How many months? _____

Did you know that the sun's rays cause harmful eye disease? Yes No

Do you wear sunglasses to protect your eyes? Yes No

Medications

List medications that you are currently taking: including eye drops

Pharmacy Name: _____

Phone #: _____

Allergies

List your allergies to medications or other substances:
