**ModernEYES Optical**
**1635 Manheim Pike • Lancaster, PA 17601**
**Phone (717) 299-0925 • Fax (717) 427-1583**

Today's date:_____/_____/_____

# Patient Information

Last Name_____ First Name_____ ☐ M ☐ F Birth date: _____/_____/_____

Address_____ City_____ State_____ ZIP_____

Preferred Phone ☐Home ☐Work ☐Cell (_____)_____ Secondary Phone ☐Home ☐Work ☐Cell (_____)_____

Email_____ Employer_____ Occupation_____

Referred by_____ Insurance Plan (if applicable)_____ School District (if applicable)_____

## *Medical & Ocular History*

**Reason for today's visit**:_____

Last eye exam (m/y):_____ Last eye doctor:_____ Last pupil dilation:_____

Do you wear: **Glasses** ☐ Yes ☐ No If yes, age of current glasses_____ **Contact lenses** ☐ Yes ☐ No If yes, what type_____

How many hours on an average day do you spend on the computer?_____ Do you have sunglasses? ☐ Yes ☐ No

Primary care physician:_____ Last visit:_____ Preferred pharmacy:_____

**Do you have any of the following conditions?** (*Check all that apply, must select at least one, write any that are not listed*)

| | | | | |
|---|---|---|---|---|
| ☐ Glaucoma | ☐ Retinal Tear/Detachment | ☐ Eye Surgery (incl Laser) | ☐ Thyroid Problems | ☐ Currently Pregnant |
| ☐ Cataracts | ☐ Strabismus (Crossed Eyes) | ☐ Double Vision | ☐ Heart Disease | ☐ Other:_____ |
| ☐ Macular Degeneration | ☐ Amblyopia (Lazy Eye) | ☐ Frequent Headaches | ☐ Cancer | ☐ Other:_____ |
| ☐ Retinal Disease | ☐ Eye Injury/Trauma | ☐ Diabetes | ☐ Rheumatoid Arthritis | |
| ☐ Uveitis/Inflammation | ☐ Blindness | ☐ High Blood Pressure | ☐ Asthma | ☐ **NONE of the above** |

Please explain any items you selected above:_____

_____

**Surgeries you have had:**_____

**Medications/Supplements/Eye Drops you take:** (include name/dosage/frequency)_____

_____

**Medication Allergies:** (include reaction) ☐ NONE ☐ penicillin ☐ other:_____

**Other Allergies:** (include reaction) ☐ NONE ☐ latex ☐ seasonal ☐ other:_____

**Personal History: Smoker**: ☐ Current ☐ Previous ☐ Never **Alcohol**: ☐ Frequent ☐ Occasional ☐ Never **Drugs**: ☐ Sometimes ☐ Never

**Do any of your relatives, living or deceased, have any of the following conditions?** (*Check all that apply, list relative(s)*)

| | | | | | |
|---|---|---|---|---|---|
| ☐ Glaucoma | _____ | ☐ Blindness | _____ | ☐ Heart Disease | _____ |
| ☐ Cataracts | _____ | ☐ Strabismus(CrossedEyes) | _____ | ☐ Thyroid Problems | _____ |
| ☐ Macular Degeneration | _____ | ☐ Amblyopia (Lazy Eye) | _____ | ☐ Cancer | _____ |
| ☐ Retinal Disease | _____ | ☐ Diabetes | _____ | ☐ Other:_____ | _____ |
| ☐ Retinal Tear/Detachment | _____ | ☐ High Blood Pressure | _____ | ☐ **NONE of the above** | |

Signature of Patient (Parent/Guardian if minor)_____ Date _____/_____/_____

*Office Use*: Date_____ ☐ Changes ☐ No Changes Initial_____
Date_____ ☐ Changes ☐ No Changes Initial_____