Boshinski Eye Clinic

5275 East Trindle Road Mechanicsburg, PA 17050 Ph: 717-697-7288 Fax: 717-697-6010

Welcome To Our Office

(Please fill out form completely)

Name: _____ Date:_____
Address: _____ Phone:_____ Cell:_____
_____ Work:_____
Birth Date: _____ email:_____
Current Ht: _____ Current Wt: _____ * needed for prescribing medications/medication history
Social Security No._____ Occupation:_____
Physician's Name: _____
Physician's Phone:_____

History/Conditions

Last Eye Exam:_____ Last Medical Exam:_____
List of Current Medications (Include oral contraceptives, hormones, vitamins, home remedies and non-prescription)
_____
_____
_____
Medicine Allergies:
_____
_____
Allergies:_____

Injuries, Surgeries, Hospitalizations: _____
_____

Check the appropriate boxes:

Flu Shot	□yes (Date-) □no	Eye Infections	□
Crossed Eyes	□	Cataracts	□
Drooping Eyelids	□	Glaucoma	□
Retinal Disease	□	Pregnant/ Nursing	□
Lazy eye	□	Eye Injuries	□
Wearing Glasses	□		
Wearing Contacts	□ (Type)_____		

Family History

(Please identify any family history including parents, grandparents, brothers sisters, children and if living or deceased)

Disease/Condition	**No**	**Yes**	**?**	**Relationship to you**
Blindness	□	□	□	_____
Cataract	□	□	□	_____
Crossed Eyes	□	□	□	_____
Glaucoma	□	□	□	_____
Macular Degeneration	□	□	□	_____
Retinal Detachment	□	□	□	_____
Retinal Disease	□	□	□	_____
Arthritis	□	□	□	_____
Cancer	□	□	□	_____
Diabetes	□	□	□	_____
Heart Disease	□	□	□	_____
High Blood Pressure	□	□	□	_____
Kidney Disease	□	□	□	_____
Lupus	□	□	□	_____
Thyroid Disease	□	□	□	_____
Other	□	□	□	_____

Pharmacy Name:_____ **Town:** _____

Social History

(This information is kept strictly confidential. You may elect to discuss this area directly with the Doctor if you prefer.)

□ Yes, I would prefer to discuss this with the Doctor.

Do you drive? □ no □ yes

If yes, do you have any visual difficulties when driving? □ no □ yes If yes, please describe:_____

_____

Do you use tobacco products? □ no □ yes If, yes, type/amount/ how long:_____

Do you drink alcohol? □ no □ yes If, yes, type/amount/ how long_____

Do you use illegal drugs? □ no □ yes If, yes, type/amount/ how long_____

Have you ever been exposed to or infected with,

□ Gonorrhea, □ Hepatitis, □ HIV, □ Syphilis

Review of Health Systems – Personal Health History

System	No	Yes	?		No	Yes	?
Constitutional				Ears, Nose, Mouth, Throat			
Fever, Weight Loss/Gain	□	□	□	Allergies/Hay Fever	□	□	□
Integumentary (Skin)	□	□	□	Sinus Congestion	□	□	□
Neurological				Runny Nose	□	□	□
Headaches	□	□	□	Post-Nasal Drip	□	□	□
Migraines	□	□	□	Chronic Cough	□	□	□
Seizures	□	□	□	Dry Throat, Mouth	□	□	□
Eyes				Respiratory			
Loss of Vision	□	□	□	Asthma	□	□	□
Blurred Vision	□	□	□	Chronic Bronchitis	□	□	□
Distorted Vision/Halos	□	□	□	Emphysema	□	□	□
Loss of Side Vision	□	□	□	Vascular/ Cardiovascular			
Dryness	□	□	□	Diabetes	□	□	□
Mucous Discharge	□	□	□	Heart Pain	□	□	□
Redness	□	□	□	High Blood Pressure	□	□	□
Sandy, Gritty Feeling	□	□	□	Vascular Disease	□	□	□
Itching	□	□	□	Gastrointestinal			
Burning	□	□	□	Diarrhea	□	□	□
Foreign Body Sensation	□	□	□	Constipation	□	□	□
Excess Tearing/Watering	□	□	□	Genitourinary			
Glare/Light Sensitivity	□	□	□	Genitals/Kidney/Bladder	□	□	□
Eye Pain, Soreness	□	□	□	Bones/Joints/Muscles			
Chronic Infection Eye or Lid	□	□	□	Rheumatoid Arthritis	□	□	□
Sties or Chalazion	□	□	□	Muscle Pain	□	□	□
Flashes/ Floaters in Vision	□	□	□	Joint Pain	□	□	□
Tired Eyes	□	□	□	Lymphatic/Hematologic			
Endocrine				Anemia	□	□	□
Thyroid/ Other Glands	□	□	□	Bleeding Problems	□	□	□
Allergic/Immunologic	□	□	□	Psychiatric	□	□	□

If you answered **YES** to any of the above, or have a condition not in the above list, please explain and list medications:

_____

_____

_____

_____OD