5275 East Trindle Road
Mechanicsburg, PA 17050
Ph: 717-697-7288
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Boshinski Eye Clinic

Welcome To Our Office
(Please fill out form completely)

Name: ______________________________ Date:______________
Address: ____________________________ Phone:______________
____________________________________ Work:______________
Birth Date ____________ email:_______________ Cell:______________
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:

Crossed Eyes	☐	Eye Infections	☐
Drooping Eyelids	☐	Glaucoma	☐
Retinal Disease	☐	Pregnant/ Nursing	☐
Lazy eye	☐	Eye Injuries	☐
Wearing Glasses	☐		
Wearing Contacts	☐ (Type and Age)________________________		

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

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