Shillington Eye Associates

Welcome To Our Office

Dr. Michael R. Mohn
Dr. Karen E. Rule
Dr. Maria R. Downey

Name: _____ **Sex: M F** **Date:** _____

Address: _____
Street City State Zip

Date of Birth: _____ **Social Security #:** _____

Home Phone: _____ **Employer (or Grade):** _____

Work Phone: _____ **Occupation (or School):** _____

Cell Phone: _____ **E-mail Address:** _____

Spouse: _____ **Spouse's Employer:** _____

Family Doctor: _____

Guarantor Information (If other than patient)

Name: _____ **Soc. Sec. #:** _____ **Date of Birth:** _____

Phone (If different from above): _____ **Employer:** _____

Address (If different from above): _____

FOR NEW PATIENTS ONLY

Whom may we thank for referring you to our office? _____
(Name please, first and last)

How did you hear about us? Friend Relative Another Dr Phone Book Web Site Insurance List

Vision Insurance:	**Medical Insurance:**
Name of Insured:	**Name of Insured:**
Soc. Sec. # of Insured:	**Soc. Sec. # of Insured:**
Date of Birth of Insured:	**Date of Birth of Insured:**

Patient Eye History

Have you ever been diagnosed with or treated for any of the following?

- ❒ cataracts
- ❒ glaucoma
- ❒ macular degeneration
- ❒ retinal detachment / tear
- ❒ eye allergies
- ❒ conjunctivitis (pink eye)
- ❒ contact lens-related disease
- ❒ corneal abrasion
- ❒ dry eye syndrome
- ❒ eye infection
- ❒ iritis / uveitis
- ❒ lazy eye / crossed eyes
- ❒ **NONE OF THESE**

Have you ever had any injuries or surgeries to your eyes? Yes No

If Yes, please elaborate: _____

Do you wear contact lenses? Yes No →

If Yes, are you satisfied with the vision and comfort? Yes No

Would you be interested in new contact lens technology that may improve your comfort or vision? Yes No

If you don't wear contact lenses:

Have you ever worn contacts? Yes No

Are you interested in trying contacts? Yes No

PLEASE TURN PAGE OVER ➡

Patient Medical History

Review of Systems - For each section, if you have no problems please check NONE

Allergic / Immunologic
- ❒ NONE
- ❒ rheumatoid arthritis
- ❒ lupus
- ❒ environmental allergy
- ❒ other

Cardiovascular
- ❒ NONE
- ❒ high blood pressure
- ❒ stroke
- ❒ vascular disease
- ❒ heart disease
- ❒ high cholesterol
- ❒ other

Genitourinary
- ❒ NONE
- ❒ kidney problems
- ❒ STD-herpes, hepatitis, chlamydia, HIV, other
- ❒ other

Endocrine (glands)
- ❒ NONE
- ❒ thyroid dysfunction
- ❒ diabetes - non-insulin dependent
- ❒ diabetes - insulin-dependent
- ❒ hormonal dysfunction
- ❒ other

Gastrointestinal
- ❒ NONE
- ❒ colitis
- ❒ reflux/GERD/ulcer
- ❒ Crohn's
- ❒ other

Musculoskeletal
- ❒ NONE
- ❒ osteoarthritis
- ❒ fibromyalgia
- ❒ osteoporosis
- ❒ other

Hematologic / Lymphatic
- ❒ NONE
- ❒ bleeding problems
- ❒ anemia
- ❒ other

Integumentary (skin)
- ❒ NONE
- ❒ eczema
- ❒ rosacea
- ❒ psoriasis
- ❒ other

General Health
- ❒ NONE
- ❒ cancer_____
- ❒ fever
- ❒ fatigue
- ❒ trauma
- ❒ weight loss
- ❒ developmental disability
- ❒ other

Neurological
- ❒ NONE
- ❒ multiple sclerosis
- ❒ epilepsy
- ❒ other

Psychiatric
- ❒ NONE
- ❒ depression
- ❒ panic disorder
- ❒ other

Respiratory
- ❒ NONE
- ❒ asthma
- ❒ emphysema
- ❒ chronic bronchitis
- ❒ other

Ears, Nose, Mouth, Throat
- ❒ NONE
- ❒ upper resp. tract infect.
- ❒ other

Are you currently being treated or medicated for any medical conditions? Yes No

What conditions are you being treated for?	What medications are you taking (Rx and over the counter)?
1.	
2.	
3.	
4.	
5.	
6.	

Are you allergic to any medications? Yes No

If Yes, please list:

Patient Social History (This information is kept strictly confidential)

Do you use tobacco products? Yes No

Do you use recreational drugs? Yes No

Please rate your alcohol consumption: None Mild Moderate Heavy

Family Medical / Eye History - Please circle any applicable condition and list relation to patient in the space provided

Blindness		Macular degeneration	
Cataracts		Retinal problems	
Corneal problems		Diabetes	
Glaucoma		High blood pressure	
Lazy/Crossed eyes		None of these	

Signature: _____ **Date:** _____

Doctor's Signature: _____ **Date:** _____