2500 Grubb Road Suite 234
Wilmington, DE 19810
brandywineeye.com

Section I: Demographics

Please fill out to the best of your ability. If not applicable, please write N/A.

Name	
DOB	
Address	
Email	
Home Number	
Cell Number	
Preferred Number to Call	□ Home □Cell
PCP	
Referring Doctor	
Preferred Pharmacy and Address	

Section II: Financial Responsibility

□*Please check the person responsible for the bills is the patient, and the contact information is the same information above. Please proceed to the next section*

Person responsible for Bills	
Address	
Phone	
Relationship to patient	

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EYE CENTER

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Section I: Medical History

- Please list any past medical history you have:

  _____

  _____

- Have you ever had any prior surgeries? □Yes □No
  - If Yes, please provide date and surgery: _____
- Do you have diabetes? If so, what was your last A1c? _____ □Yes □No

Section II: Ocular History

- When was your last eye exam? _____
- Who was your last eye doctor? _____
- Have you been diagnosed with any ocular history in the past? I.e. cataracts, glaucoma, macular degeneration, diabetic retinopathy, amblyopia, retinal tears, or detachment? □Yes □No
  - Please list any relevant information (drops/lasers/prior doctors):

    _____

    _____
- Have you had eye surgeries? □Yes □No
  - If Yes, please state below: _____
- Do you take any eye drops? □Yes □No
  - If Yes, please state below: _____

Section III: Medications, Allergies, Social History, Family History

- Please list any medications you take (if you have a list, please provide to the receptionist):

  _____

  _____

- Do you have any allergies? □Yes □No
  - If Yes, please list drug and reaction:

    _____
- Do you smoke? □Yes □No
  - If Yes, please provide number of cigarettes/day: _____
- Do you drink? □Yes □No
  - If Yes, please provide number of drinks/week: _____
- Do any medical or eye diseases that run in your family? □Yes □No
  - If yes, please state below:

    _____

    _____