BRANDYWINE
EYE CENTER

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	
Birth Sex	□Male □Female
Race	□White □Black/African American □American Indian or Alaskan Native □Asian □Native Hawain or Pacific Islander □Other: ___________________
Language	□English □Spanish □Mandarin □Hindi □Arabic □Russian □Other: _____________
Email	
Home Number	
Cell Number	
Preferred Number to Call	□ Home □Cell
Able to leave message?	□Yes □No
SSN	
Occupation	
Employer	
Emergency Contact: Name **AND** phone number	

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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	

Section III: Doctors and Pharmacies

Primary Doctor	
Referring Doctor	
Other (cardiologist, endocrinologist, etc.)	

Preferred Pharmacy (to send medications electronically)	
Address	

Section IV: Auto Accident/Employment Information

□ *Please check this box if your visit does **NOT** pertain to any auto accident, employment or other accident issues. Please proceed to the next section.*

Is this condition related to	□ Employment □ Auto Accident? □ Other accident?
Date of Accident/Injury	
Claim #	
Adjuster/Contact/Phone #	
Insurance Name and Address	

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Section I: Chief Complaint and Medical History

What brings you into the office today?____

- 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? □Yes □No
  - What was your last A1c? _____

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:

  ____

  ____

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

    ____

    ____

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- 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:

    ____

    ____

Section IV: Quality Measures

- For patients over 65 and older: Have you received a pneumonia vaccination? □ Yes □ No

- Do you have a health proxy in the event you are unable to make your own medical decisions? □ Yes □ No

Section V: Review of Systems

Do you have any of the following problems:

- Chronic fever or unexpected weight loss/gain □ Yes □ No
  - If yes, please explain: _____________________________________
- Ear, nose or throat problems (e.g. hearing loss, sinus problems, sore throat) □ Yes □ No
  - If yes, please explain: _____________________________________
- Heart problems (e.g., chest pain, irregular heartbeat, heart attack) □ Yes □ No
  - If yes, please explain: _____________________________________
- Respiratory problems (e.g. shortness of breath, wheezing, coughing) □ Yes □ No
  - If yes, please explain: _____________________________________
- Gastrointestinal problems (heartburn, abdominal pain, diarrhea) □ Yes □ No
  - If yes, please explain: _____________________________________
- Urinary problems (e.g., pain or discomfort, blood in urine) □ Yes □ No
  - If yes, please explain: _____________________________________
- Skin problems (e.g., rashes, excessive dryness) □ Yes □ No
  - If yes, please explain: _____________________________________
- Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints) □ Yes □ No
  - If yes, please explain: _____________________________________
- Neurological problems (e.g., numbness, weakness, headaches, paralysis, stroke) □ Yes □ No
  - If yes, please explain: _____________________________________
- Psychiatric problems (e.g. depression, anxiety) □ Yes □ No
  - If yes, please explain: _____________________________________