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	
Status	□Single □Married □Other: _____
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	

BRANDYWINE
EYE CENTER

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

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	

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

Section I: Chief Complaint and Medical History

What brings you into the office today?_____

- Please list any past medical history you have:_____
- Do you have any of the conditions below?
  - DIABETES: □Yes □No
    - If Yes, do you take insulin? □Yes □No
    - What was your last A1c? _____
  - HIGH BLOOD PRESSURE: □Yes □No
- Have you ever been hospitalized? □Yes □No
  - If Yes, please provide date and reason: _____
- Have you ever had any surgeries? □Yes □No
  - If Yes, please provide date and surgery: _____
- Please list any medications you take:_____

Section II: Ocular History

- When was your last eye exam? _____
- Who was your last eye doctor? _____
- Do you take any eye drops? □Yes □No
  - If Yes, please state below: _____
- Have you had eye surgeries? □Yes □No
  - If Yes, please state below: _____
- Have you been diagnosed with GLAUCOMA? □Yes □No
  - Have you or are you currently taking any eye drops? _____
  - Have any laser been performed? _____
  - Have any surgeries been performed? _____
- Have you been diagnosed with MACULAR DEGENERATION? □Yes □No
  - Are you taking any eye vitamins? If so, which ones? _____
  - Have you had injections in the eye? If so, how many and what medication?
    _____
  - Have any surgeries been performed? _____
- Have you been diagnosed with DIABETIC RETINOPATHY? □Yes □No
  - If yes, have you had any treatment for this condition? _____

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

- Have you been diagnosed with AMBLYOPIA? □Yes □No
  - Did you have any surgeries to correct this? _____
- Have you been diagnosed with any RETINAL TEARS OR DETACHMENT? □Yes □No
  - When and how was it treated? _____

Section III: Family and Social History

- Do any medical or eye diseases run in your family? □Yes □No
  - If yes, please state below: _____
- Do you smoke? □Yes □No
  - If yes, please state how much: _____
- Do you drink? □Yes □No
  - If yes, please state how much: _____

Section IV: 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: _____