DR. TED F. BUKOWSKI AND ASSOCIATES, P.C.

PATIENT HISTORY FORM

Please answer all questions. Most systemic diseases can sometimes be detected during an eye examination, making it necessary for us to take a complete medical history. The requested information is required by all health care insurance providers.

Name:_____ Date of Exam:_____

Marital Status (circle): **S M Other**

Occupation:_____

Pharmacy:_____

Pharmacy's address, if Known: _____

Pharmacy's telephone, if known:_____ Fax, if known: _____

Primary care physician:_____ _____

Office address, if known:_____

Office telephone, if known: _____ Fax, if known: _____

Height: _____ft. _____in. Weight: _____lbs. (We will measure your height and weight at your request)

Hobbies:_____

Do you smoke tobacco? **Y N** Have your ever smoked? **Y N**

If yes, do you smoke daily? **Y N** What type of tobacco? _____ If former smoker,

Approximate date that you smoked for the last time: _____

Do you drink alcohol? **Y N** If yes, How many drinks per week?_____ What type of alcohol?_____

Email address: _____ In this day of EHR's (electronic health records), email is the preferred and most efficient way of contacting patients for appointments and for business related matters. Is email an acceptable media for our staff to communicate with you? **Y N** How else may we contact you to handle these matters? Please circle: **Telephone Text US Mail Fax**
The doctor will often will text patients when urgent or frequent communication is needed. Do you communicate by text? **Y N**

New patients, or patients that haven't been seen in 3 years or more, please fill in all of the information below. Established patients my fill in changes only since the last visit.

Patient's home address:_____ Telephone (circle best number to call)

Town: _____State:____Zip:_____ H:_____W:_____

C:_____

Date of Birth:_____Age:_____Sex: **M F** **OVER>>>>>>>>>>**

Do you wear glasses now? **Y N** If yes, for **distance**, **reading**, or **both**? (circle one).
Do you want to wear contact lenses? **Y N** Have you worn contact lenses before? **Y N**
Briefly describe the main problem that you are having with your vision or with your eyes:

Please circle any of the following visual symptoms or other problems that you have experienced: flashes of light floaters double vision sudden loss of vision frequent headaches eye pain blurred vision light sensitivity dryness burning itching discharge from eyes eye injury eye surgery cataracts glaucoma macular degeneration
other_____ *Check here if none of the above apply:____

Does anyone in your family have any of the above eye problems? **Y N** If yes, please fill in that information below:

Please circle any medical conditions that you have: high blood pressure diabetes high cholesterol heart disease thyroid problems cancer any autoimmune disease any neurological disease sleep apnea other_____
*check here if none of the above apply____

Does anyone in your family have any of the above medical problems? **Y N** If yes, pleas fill in that information below.

Please list all of the medications, both prescription and over the counter, that you are currently taking. If you have a list with you, then we can just make a copy of that.

Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you aware of any medical allergies? **Y N** If yes, please list:_____