EYE SOLUTIONS OF SYRACUSE
LAWRENCE CECCHI, MD

CATARACT | EYELID | LASER SURGERY

Reset Form Print Form

Welcome to our office

Please fill out the following information completely.
Please arrive as close to your scheduled time as possible, and allow yourself at least one hour for the examination. If we should need to preform any special testing during your exam it will take longer. We respect your time and do our best to stay on time.

☐ Mr. ☐ Mrs. ☐ Miss

Name: (Last) _____ (First) _____ (M.I.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____ Gender: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ American Indian/ Alaskan Native ☐ Asian/Pacific Islander ☐ Asian
☐ Caucasian ☐ Black or African American ☐ Hispanic ☐ Other

Ethnicity: ☐ American ☐ Other (list) _____

Preferred Language: ☐ English ☐ Spanish ☐ Other

Employed: ☐ No ☐ Yes ☐ FT ☐ PT ☐ Retired

Employer Name: _____

Employer Phone Number: _____

Name of referring ☐ Doctor ☐ Optometrist or ☐ Patient: _____

Primary Care Physician: _____

Pharmacy you use: _____ Location: _____

PLEASE BRING YOUR INSURANCE CARDS AND PHOTO ID WITH YOU TO BE SCANNED

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Patient Name: _____ DOB: _____

Eye History:

Have you experienced or been diagnosed with any of the following:

- ☐ Cataract
- ☐ Retinal Detachment
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Dry Eyes
- ☐ Migraines
- ☐ Amblyopia
- ☐ Macular Degeneration
- ☐ Other

Please describe the reason for your visit: _____

_____

Have you ever experienced a serious eye injury or had eye surgery? ☐ Yes ☐ No

Explain: _____

Date of your last exam: _____

Please list any eye drops or eye medications you are currently using: _____

_____

Medical History:

Have you ever been diagnosed with any of the following?

- ☐ Asthma
- ☐ Cancer
- ☐ Heart Disease
- ☐ Stroke
- ☐ Arthritis
- ☐ Bleeding Disorder
- ☐ Thyroid
- ☐ High Blood Pressure
- ☐ Diabetes

Please list your current medications and dosages:

_____ _____ _____

_____ _____ _____

Do you have any medication allergies? ☐ Yes ☐ No

If so, please list: _____

Please list prior major surgeries: _____

_____

Social History:

Do you smoke? ☐ Yes ☐ No If so, how many packs per day? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

If so, how much? ☐ Socially ☐ With Meals ☐ 2-3 Per Week ☐ More _____

Are you pregnant or planning? ☐ Yes ☐ No

Reviewed with patient by: _____ On: _____

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Family History:
Has anyone in your immediate family been diagnosed with any of the following?

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Cataract	○	○	○	○	○	○	○	○	○
Glaucoma	○	○	○	○	○	○	○	○	○
Macular Degeneration	○	○	○	○	○	○	○	○	○
Crossed or Lazy Eye	○	○	○	○	○	○	○	○	○
Retinal Detachment	○	○	○	○	○	○	○	○	○
Blindness	○	○	○	○	○	○	○	○	○
Dry Eyes	○	○	○	○	○	○	○	○	○
Migraines	○	○	○	○	○	○	○	○	○
Amblyopia	○	○	○	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○	○	○	○
Other	○	○	○	○	○	○	○	○	○