Oxford Family Eye Care
Dr. Malcolm H. Kelly, Jr.
49 South Second Street
Oxford, PA 19363
(610) 932-9356
Office.ofec@gmail.com

First Name _____M.I. _____ Last Name _____

Address_____
Street Address City / State / Zip

Birth Date ____/____/____

Social Security # _____ or Last 4 digits _____

Language Preference ☐ English ☐ Spanish

Race: ☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other
☐ Declined

Please check Preferred Phone #

Home Phone_____ ☐

Work Phone_____ ☐

Cell Phone_____ ☐

Email _____
We will not share your email with marketers

Communication Options

	Y / N	Phone H	W	C	Email	Text	None
Appt. Conf	☐ ☐	☐	☐	☐	☐	☐	☐
Recall	☐ ☐	☐	☐	☐	☐	☐	☐
Orders	☐ ☐	☐	☐	☐	☐	☐	☐

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined Martial Status ☐ Single ☐ Married ☐ Other

Guarantor Information: Who will be responsible for payment:

Guarantor Name _____ Date of Birth ____/____/____

Address if different to patient: _____

Contact Phone # _____ Social Security # _____ or Last 4 digits _____

Patient's Current Employer / School _____ Position / Grade _____

Marital Status ☐ Single ☐ Married ☐ Other

PATIENT MEDICAL HISTORY

Name of family physician _____

City _____ Date of last physical exam _____

CURRENT MEDICATIONS

Prescription and over the counter – please include eye drops, inhalers, vitamins, herbal supplements, birth control pills and any other medication. Please include dosage of each medication if applicable

_____

_____

Please list any medications/materials you are ***allergic*** to _____

List any surgeries and the date _____

Do you use cigarettes or tobacco? ○ Yes ○ No

Do you drink alcohol? ○ Yes ○ No

Have your ever been diagnosed or treated for :

	Yes	No
Aids / HIV	○	○
Anxiety Disorder	○	○
Arthritis	○	○
Blood / Lymph	○	○
Cancer	○	○
Depression	○	○
Diabetes	○	○
Ear / Nose / Throat	○	○
Elevated Cholesterol	○	○
Eczema / Rashes	○	○
Emphysema	○	○
Genitourinary	○	○
High Blood Pressure	○	○
Kidney	○	○
Lupus	○	○
MS	○	○
Muscle / Bone	○	○
Parkinson's Disease	○	○
Sinus	○	○
Sjogren's Syndrome	○	○
Stroke	○	○
Thyroid	○	○
Tumor	○	○
Other	○	○

Please explain:

Do you currently wear glasses? ○ Yes ○ No

If you wear bifocals, do the lines or head tilting bother you?

Do you currently wear contact lenses?

What brand? _____ Toric Soft

What solution do you use?_____

Are you satisfied with the vision and comfort of your contact lenses?

If available, would you prefer Clear or Colored

Routine exam coverage DOES NOT include Contact Lens Exam, fit and follow up.

Have you ever experienced, been diagnosed or treated for:

- ○ Eyestrain
- ○ Blurry Vision
- ○ Cataracts
- ○ Crossed Eye / Lazy Eye
- ○ Eye Infection
- ○ Redness
- ○ Floaters / Spots
- ○ Glaucoma
- ○ Headaches / Migraines
- ○ Itchiness
- ○ Sunlight Sensitivity
- ○ Retinal Detachment
- ○ Uncomfortable Glasses
- ○ Total loss of vision
- ○ Burning
- ○ Corneal Abrasions
- ○ Double Vision
- ○ Eye Injury
- ○ Flashes of Light
- ○ Grittiness
- ○ Iritis / UVeltis
- ○ Dry Eye
- ○ Macular Degeneration
- ○ Trouble seeing at night
- ○ Tearing

Other, please explain

FAMILY MEDICAL HISTORY

Is there a family medical history of any of the following?
Please check box and list relationship to you (Mother, Father, Sister, Brother, Children)

Cancer	○	_____
Diabetes	○	_____
Hypertension	○	_____
Hyperthyroidism	○	_____
Hypothyroidism	○	_____
Cataracts	○	_____
Macular Dengeneration	○	_____
Glaucoma	○	_____