

CENTRAL PENNSYLVANIA EYE INSTITUTE

MEDICAL INFORMATION

Patient Name _____ Date of Birth _____ Age _____
 Social Security Number _____ Sex _____
 Address _____
 _____ (Street) _____ (City) _____ (State) _____ (Zip)
 Home Phone _____ Work Phone _____ Cell Phone _____
 Email Address _____

Phone number of nearest friend/relative in the event of emergency.
 Name _____ Phone _____

Name, address and phone number of **referring physician**: _____

Name, address and phone number of your **Optometrist or Ophthalmologist**: _____

Name, address and phone number of your **personal/family doctor/other physicians**:

Do you want a copy of your report sent to your doctor? Yes No
 If yes, to whom? Family Dr. Ophthalmologist Optometrist

Chief Complaint (Reason why you are here today) _____

Type of Health Care Insurance:

Medicare Blue Shield HMO
 Commercial Medical Assistance Private Pay

PRIMARY INSURANCE: _____

 (name of policy holder/subscriber) (Date Of Birth) (S.S.#) (policy #)

 (employer's name, address and phone number)

SECONDARY INSURANCE: _____

 (name of policy holder/subscriber) (Date Of Birth) (S.S.#) (policy #)

 (employer's name, address and phone number)

CONTINUE ON BACK

Past Medical History

1. Current Medications

2. Medications/Allergies

3. Past Surgical
Medical/History

Family History of: (Has anyone in your family had any of the following?)

Cataract	_____ Yes _____ No	High Blood Pressure	_____ Yes _____ No
Glaucoma	_____ Yes _____ No	Heart Disease	_____ Yes _____ No
Macular Degen.	_____ Yes _____ No	Eye Disorders	_____ Yes _____ No
Retl Detachment	_____ Yes _____ No	Other	_____
Arthritis	_____ Yes _____ No	Other	_____
Diabetes	_____ Yes _____ No	Other	_____

Review of systems: (Do you currently have any problems in the following areas?)Constitutional

___ Fever

___ Weight loss

___ Other

___ None

Eyes

___ Blurred vision

___ Double vision

___ Pain

___ None

Ears, Nose, Mouth

___ Pain

___ Mass

___ Discharge

___ None

Cardiovascular

___ Chest pain

___ Short of breath on exertion

___ Irregular heart beat

___ Other

___ None

Respiratory

___ Short of breath

___ Cough

___ Asthma

___ Other

___ None

Gastrointestinal

___ Bowel changes

___ Diarrhea

___ Constipation

___ Stomach pain

___ Ulcers

___ None

Hematologic/Lymphatic

___ Anemia

___ Blood disease

___ Free bleeder

___ Swollen lymph nodes

___ Other

Muscular

___ Weakness

___ Joint pain

___ Decreased Range
of motion

___ Other

Integumentary (skin)

___ Masses

___ Tumors

___ Pigmented lesions

___ Rash

___ None

Neurologic

___ Weakness

___ Tingling

___ Numbness

___ Other

___ None

Kidney/Bladder

___ Dialysis

___ Pain on urination

___ Urinary incontinence

___ Other

___ None

Social History

Drugs _____ Yes _____ No

Married ____ Divorced ____ Life Partner _____

Alcohol _____ Yes _____ No

Single ____ Widow ____

Tobacco _____ Yes _____ No

Living Alone _____ Yes _____ No

Have you lived in a foreign country for a substantial period of time? _____ Yes _____ No
If Yes, Where? _____

Have you ever had a blood transfusion? _____ Yes _____ No

Have you ever been in intimate contact with a person who had a sexually transmitted disease? _____ Yes _____ No Are you known to be HIV positive? _____ Yes _____ No

We may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- HIV (AIDS virus)
- Sexually transmitted diseases
- Drug and/or alcohol use

Occupation: _____
(name) (address) (phone number)

How did you find out about us...

____ Hershey White Pages

____ Harrisburg White Pages

____ Hershey Yellow Pages

____ Harrisburg Yellow Pages

____ Walk-In

Other _____

Physician's initials
Technician's initials