EXTON VISION CENTER

THE COMMONS AT LINCOLN CENTER

121 JOHN ROBERT THOMAS DRIVE

EXTON, PA 19341

610-363-6203

PATIENT DATA

LAST NAME ____________ FIRST ____________ MI ____

ADDRESS ____________ CITY ____________ STATE ____ ZIP ____

WORK NUMBER (   ) ____________ HOME PHONE (   ) ____________ SSN ____ - ____ - ____

DOB ____________ OCCUPATION ____________ EMPLOYER ____________

EMERGENCY CONTACT NAME ____________ PHONE NUMBER (   ) ____________

DATE OF LAST EYE EXAM ____________ DILATED? YES/NO ____________

TODAY'S DATE ____________ REFEREED BY ____________

INSURANCE INFORMATION

NAME OF INSURANCE ____________ ID# ____________ GROUP # ____________

ADDRESS ____________

NAME OF INSURED ____________ TELEPHONE NUMBER (   ) ____________

MEDICAL INFORMATION

WHAT IS YOUR GENERAL HEALTH? ____________

DO YOU HAVE PROBLEMS WITH ANY OF THESE SYSTEMS? (PLEASE CIRCLE YES OR NO.)

GASTROINTESTINAL	YES/NO	NERVOUS	YES/NO	ENDOCRINE(GLANDS)	YES/NO
EARS/NOSE/THROAT	YES/NO	URINARY	YES/NO	BLOOD/LYMPH	YES/NO
CARDIOVASCULAR	YES/NO	MUSCLES/BONES	YES/NO	ALLERGIC/IMMUNOLOGIC	YES/NO
RESPIRATORY	YES/NO	INTEGUMENTARY (SKIN)	YES/NO	HEADACHES	YES/NO
HIGH BLOOD PRESSURE	YES/NO	EYES	YES/NO	MENTAL	YES/NO

PLEASE EXPLAIN ____________

DIABETES YES/NO TYPE ____________ DATE OF DIAGNOSIS ____________

ALLERGIES TO MEDICATION? YES/NO WHICH? ________________ REACTION ____________

OTHER HEALTH PROBLEMS ____

CURRENT MEDICATION (S) ______________________________________ CHECK IF NONE ______

HAVE YOU HAD ANY OPERATIONS? YES/NO KIND? ______________ WHEN? __________________

NAME OF FAMILY DOCTOR ____

PHONENUMBER ( ) ______________________________ DATE OF LAST VISIT ______________

FAMILY HISTORY

HIGH BLOOD PRESSURE YES/NO RELATION ____

DIABETES YES/NO RELATION ____

GLAUCOMA YES/NO RELATION ____

MACULAR DEGENERATION YES/NO RELATION ____

RETINAL DETACHMENT YES/NO RELATION ____

CATARACTS YES/NO RELATION ____

PERSONAL EYE INFORMATION

DO YOU HAVE ANY EYE CONDITIONS OR PROBLEMS? YES/NO

WHAT KIND? ____

HAVE YOU HAD ANY EYE OPERATIONS? YES/NO

TYPE ____ DATE ________________

HAVE YOU HAD AN EYE INJURY? YES/NO

KIND ____ DATE ________________

DO YOU HAVE GLAUCOMA? YES/NO CATARACTS? YES/NO

DRY EYES? YES/NO MACULAR DEGENERATION? YES/NO

RETINAL DETACHMENT? YES/NO BLURRED VISION? YES/NO

DO YOU WEAR GLASSES? YES/NO CONTACT LENSES? YES/NO TYPE ____________

ADDITIONAL INFORMATION ____