MEMORIAL EYE INSTITUTE

4100 Linglestown Road
Harrisburg, PA 17112

717-657-2020
800-382-2020 toll free

Today's Date _____

Patient Name _____ Age _____ Birthdate _____
Address _____ Home phone _____
City _____ State _____ Zip _____ Business phone _____
Employer _____ Address _____
How did you hear about us? _____
Who is your current eye doctor? _____
When was your last eye exam? _____

If child: Father's name _____
Father's employer _____
Father's business phone _____
Mother's name _____
Mother's employer _____
Mother's business phone _____

If married: Spouse's name _____
Spouse's employer _____
Spouse's business phone _____

Do you have Medicare? _____ Medicare # _____
Do you have Medical Assistance? _____
Other Ins. Co. Name _____
Group # _____ Agreement # _____
Patient Social Security # _____
Name, address & phone of your medical doctor _____

When was your last change in eyeglasses or contacts? _____
What doctor ordered the change? _____
What is your reason for your eye examination today? _____
routine exam _____ injury _____
problem _____ other, please explain _____

In case of an emergency:
Name _____ Relationship _____ Phone# _____

To what MEDICINES are you ALLERGIC? ( ) Penicillin ( ) Sulfa ( ) Steroids
( )Aspirin ( )Other-List Them _____

Are you Allergic to any EYE DROPS? ( ) Yes ( ) No If yes, Identify _____

Please check YES or NO for the following:

1. Diabetes			How Long?_____ Medication _____
2. High Blood Pressure			How Long?_____ Medication _____
3. Heart Disease			How Long?_____ Medication _____
4. Cancer			How Long?_____ Medication _____
5. Arthritis			How Long?_____ Medication _____
6. Lung Disease			How Long?_____ Medication _____
7. Glaucoma			How Long?_____ Medication _____
			Had Surgery?_____ Which Eye?_____ When?_____
8. Cataracts			How Long?_____ Surgery? _____ When?_____
			Intraocular Lens Implant? _____

9. Do you wear contacts?_____ How Long?_____ Hard_____Soft_____Ex. Wear_____
10. Taking Birth Control Pills?_____ How Long?_____ Medication _____
11. Have Lazy Eye(Amblyopia)_____ How Long?_____ Which Eye?_____

Is there a family history of any of the above diseases?_____Which?_____

List any medical conditions you have _____

What other medicines do you take? _____

Have you ever had an eye examination? _____ Date of last exam_____

Name and address of examiner_____

Do you use eye drops?_____ Please List _____

Have you ever been hit in the eye?_____ When?_____Which Eye? _____

What eye surgery have you had?_____

Are you or have you ever been cross eyed? _____ Wall-eyed?_____

Signature of Patient	Date	Signature of Responsible Party	Date