Central Vision Eyecare LLC

New Patient Form

Patient Name: _____ Date of Birth: _____ SSN: _____
Referring Doctor: _____ Family Physician: _____ Pharmacy: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Email Address: _____

Medications: Attach a list of current medications or list them below. Include over the counter and prescription medications

Name of Medication	Purpose for Medication	Dosage	Frequency

Allergies & Reactions:

Previous Surgeries:
Previous Eye Surgergies:

Family History:

Relationship:
F-Father, M-Mother, B-Brother, S-Sister, GM-Grandmother, GF-Grandfather

- ◯ Y ◯ N Cataracts _____
- ◯ Y ◯ N Glaucoma _____
- ◯ Y ◯ N Macular Degeneration _____
- ◯ Y ◯ N Cancer _____
- ◯ Y ◯ N Diabetes _____
- ◯ Y ◯ N High Cholesterol _____
- ◯ Y ◯ N High Blood Pressure _____

Social History: Circle all that apply

Use of tobacco: ◯ Current ◯ Former ◯ Never

Use of Alcohol: ◯ Occasional ◯ Heavy ◯ None

Do you receive a Pnemonia Vaccine? ◯ Y ◯ N

Do you receive a Flu Vaccine? ◯ Y ◯ N

Are you a Fall Risk? ◯ Y ◯ N

Do you Drive? ◯ Y ◯ N

List of Current Medical Conditions on the back

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23 South Arch St
Milton PA 17847

30 Choate Cir #2
Montoursville, PA 17754

4504 Westbranch Hwy
Lewisburg, PA 17837

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Current Medical Conditions

Condition		Condition	
Fever	◯Y ◯N	Arthritis	◯Y ◯N
Headaches	◯Y ◯N	Osteoarthritis	◯Y ◯N
Dementia	◯Y ◯N	Fibromyalgia	◯Y ◯N
Alzheimer's	◯Y ◯N	Multiple Sclerosis	◯Y ◯N
Sjogrens	◯Y ◯N	Gout	◯Y ◯N
Rosacea	◯Y ◯N	History of Bell's Palsy	◯Y ◯N
Psoriasis	◯Y ◯N	Stroke	◯Y ◯N
Eczema	◯Y ◯N	Migraines	◯Y ◯N
Hearing Loss	◯Y ◯N	Seizures	◯Y ◯N
Wear Hearing Aids	◯Y ◯N	Parkinson's	◯Y ◯N
Tinnitus/ Ringing in ears	◯Y ◯N	Thyroid Diease	◯Y ◯N
Dizziness or Spinning Sensation	◯Y ◯N	Diabetic	◯Y ◯N
Asthma	◯Y ◯N	Type Last A1C	◯Y ◯N
COPD	◯Y ◯N	Cushing's	◯Y ◯N
Seasonal Allergies	◯Y ◯N	Depression or Anxiety	◯Y ◯N
High Blood Pressure	◯Y ◯N	Bi Polar or Schizophrenia	◯Y ◯N
High Cholesterol	◯Y ◯N	ADD or ADHD	◯Y ◯N
A-Fib	◯Y ◯N	Anemia	◯Y ◯N
Heart Disease	◯Y ◯N	Sarcoidosis	◯Y ◯N
GERD	◯Y ◯N	Lupus	◯Y ◯N
Acid Reflux	◯Y ◯N	Lyme's	◯Y ◯N
Crohn's	◯Y ◯N	HIV / Aids / Hepatitis	◯Y ◯N
IBS	◯Y ◯N	Shingles / Herpes	◯Y ◯N
Prostate Problems	◯Y ◯N	Cataracts	◯Y ◯N
Overactive Bladder	◯Y ◯N	Glaucoma	◯Y ◯N
Currently Pregnant	◯Y ◯N	Macular Degeneration	◯Y ◯N

Please list any other systemic illnesses: _____

Last Eye Exam: _____ **Do you wear glasses?** ◯Y ◯N ◯Readers Only

Do you wear contacts? ◯Y ◯N

Brand: _____ ◯Monthly ◯Daily ◯RGP

Current Glasses TX:

Right Eye: _____ **Left Eye:** _____

Signature: _____ Date: _____

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