Patient health History and Registration Form

Patient's Name _____ (First) _____ (Last) _____ (MI) _____ (Today's Date)

Race _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic Primary Language _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip) _____ (Email)

Phone _____ (Home) _____ (Cell) _____ (Work) _____ (Ext.) _____ (Employer / Occupation)

Date of Birth _____ Age _____ Gender _____ Last Eye Exam _____ Last Medical Exam _____

Account Responsible Same as above ☐

Name _____ (First) _____ (Last)

Address _____ (Street) _____ (City)

Phone _____ (Best Contact #) _____ (State) _____ (Zip)

Insurance? Member# or Social Security# _____

Medical _____ (Primary) _____ (Secondary)

Vision _____ Insured's Date of Birth _____

Insured's Name _____ (First) _____ (Last)

Today's Method of Payment: Cash ☐ Check ☐ Visa ☐ Mastercard ☐ Discover ☐

Medical History

Do you have any allergies to medications? ☐ No ☐ Yes If yes, please list: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies:

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, eye infections, or eye injuries: _____

Do you wear glasses? ☐ No ☐ Yes Are you planning to get new glasses today? ☐ No ☐ Yes If My Rx Changs ☐

Do you wear contact lenses? ☐ No ☐ Yes If no, are you interested in wearing contact lenses? ☐ No ☐ Yes

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended wear ☐ Other Are they comfortable? ☐ No ☐ Yes

Family History

Please note any family history(parents, grandparents, siblings, children, living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment/Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other _____	☐	☐	☐	

Please turn this form over and complete side two!

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.
☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes If yes, please describe below:

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long: _____

Do you drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long: _____

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

	NO	YES	?
CONSTITUTIONAL	☐		
Fever, Weight Loss / Gain	☐	☐	☐
INTEGUMENTARY(Skin)	☐	☐	☐
NEUROLOGICAL	☐		
Headaches	☐	☐	☐
Migraine	☐	☐	☐
Seizures	☐	☐	☐
EYES	☐		
Blurred Vision	☐	☐	☐
Loss of Vision	☐	☐	☐
Distorted Vision / Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing / Watering	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Infection of Eye or Lid	☐	☐	☐
Sties or Chalazion	☐	☐	☐
Flashes / Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE	☐		
Thyroid / Other Glands	☐	☐	☐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT	☐		
Allergies / Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat / Mouth	☐	☐	☐
RESPIRATORY	☐		
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR	☐		
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL	☐		
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY	☐		
Genitals / Kidney / Bladdar	☐	☐	☐
BONES / JOINTS / MUSCLES	☐		
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC	☐		
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC	☐	☐	☐

If you answered YES to any of the above or have a condition not listed please explain below if necessary:

Thank you for taking the time to fill out your registration and health history form.
This information will help us bill your insurance and provide you with a more thorough eye exam.

FOR DOCTOR USE:

REV:_____/_____/_____ REV:_____/_____/_____

REV:_____/_____/_____ REV:_____/_____/_____

Doctor's Signature Date