Patient Registration & Health History Form

Patient's Name: _____ Date of Birth: _____ SSN: _____-_____-_____

(If patient is under 18) Parent/Guardian's Name: _____ Parent/Guardian DOB: _____

I was referred by: ☐ Friend _____ ☐ Website ☐ Driving By ☐ Other _____

Do you have family history of any of the following: (check any/all that apply)

☐ Cataract ☐ Age-related Macular Degeneration ☐ Glaucoma ☐ Diabetes ☐ Blindness

Do you have any of the following: (check any/all that apply)

Eye Conditions:

☐ Cataract
☐ Age- related Macular Degeneration
☐ Glaucoma
☐ Diabetes
☐ Blindness
☐ Diabetic Retinopathy
☐ Dry Eye
☐ Eye Infection, Inflammation, or Allergy
☐ Floaters and / or Flashes of Light
☐ Iritis or Uveitis
☐ Cross Eye / Lazy Eye
☐ Retinal Defects Or Detachment

Eye Concerns:

☐ Redness
☐ Burning
☐ Itching
☐ Tearing
☐ Discharge
☐ Trauma

REQUIRED Please indicate Patient's Height & Weight.
Height: _____ft. _____in.
Weight: _____lbs.

Vision Concerns:

☐ Blurred Vision
☐ Eyestrain
☐ Severe Sensitivity to light
☐ Headaches
☐ Poor Night Vision
☐ Bothersome Night Glare
☐ Double Vision
☐ Total Loss of Vision
☐ Migraines
☐ Other _____
_____
_____

Do you wear glasses? ☐ Yes ☐ No — If Yes: ☐ Reading Only ☐ Near ☐ Far Away

Do you wear contact lenses? ☐ Yes ☐ No — If Yes: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other: _____

Is your vision clear or blurred? ☐ Clear ☐ Blurred — If Blurred: ☐ Distance ☐ Near ☐ Both

Have you had eye surgery? ☐ Yes ☐ No — If Yes: ☐ LASIK ☐ Cataract ☐ Other _____

If No: Are you interested in learning about LASIK? ☐ Yes ☐ No

Past Medical, Family & Social History (PFSH):

Primary Physician: _____ Preferred Pharmacy: _____

Race: ☐ White ☐ African American ☐ Native American ☐ Asian ☐ Other _____ ☐ Decline to Answer

Ethnicity: ☐ Hispanic/ Latino ☐ Non Hispanic/Latino

Primary Language: ☐ English ☐ Spanish ☐ Other _____

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Have you received Flu Shot: ☐Yes ☐No

Are you Pregnant and/or Nursing: ☐Yes ☐No

Do you consume alcohol: ☐Yes ☐No ☐Occasional

If Yes or Occasional: Amount / How Long: _____

Do you use tobacco: ☐Yes ☐Never ☐Former

If Yes or Former: Type: _____ Amount / How Long: _____

List any past medical issues related to your eyes: _____

List any medical or ocular issues within your immediate family: _____

Please explain or list any other health related issues or concerns: _____

Medications:

Are you currently taking any medications? ☐ Yes ☐ No If Yes, Please Explain: _____

Allergies:

Are you allergic to any medications? ☐ Yes ☐ No If Yes, Please Explain: _____

List any other allergies you may have: _____

Health History (Circle all that apply)

ENT
- ☐ Hearing Loss
- ☐ Sinuses
- ☐ Dry Mouth
- ☐ Laryngitis

Cardiovascular
- ☐ High Blood Pressure
- ☐ Stroke / CVA
- ☐ Vascular Disease
- ☐ Congestive Heart Failure

Respiratory
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction

GU
- ☐ Kidney Disease
- ☐ Prostate Disease / Cancer
- ☐ Benign Prostate Hypertrophy
- ☐ STD _____

Musc/Skel
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Muscular Dyst.
- ☐ Ankylosing Spondylitis

GI
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease

Integ
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Cold Sores
- ☐ Shingles

Neuro
- ☐ Migraines
- ☐ Tumor
- ☐ Stroke
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Multiple Sclerosis

Psychiatric
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder

Endo
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Borderline Diabetic
- ☐ Thyroid
  - ☐ Hyper ☐ Hypo

Hem/Lymph
- ☐ Anemia
- ☐ Ulcer
- ☐ High Cholesterol
- ☐ Large-volume blood loss

Allergy/Immune
- ☐ Drug Allergies
- ☐ Environment Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome

Contact Lenses

Recent developments in contact lenses have made it possible for nearly all prescriptions to be fit in contacts. We offer most prescriptions in a new, more comfortable material called Silicon Hydrogel. If you were unable to wear contacts in the past, due to dry eyes or comfort issues, this new material may now enable you to wear contact lenses.

☐ **Yes**, I am interested in seeing if contact lenses are right for me.

☐ **No**, I am not interested in contact lenses..

Dilation

In many instances, the doctor may recommend pupil dilation as part of your exam. This involves putting drops in each eye and then waiting for approximately 15 minutes for the pupil size to increase. Dilation of the pupil enables a more complete health check by allowing the doctor to see more of the internal structures of the eye. If the doctor recommends that your eyes be dilated please check the box indicating your response.

☐ **Yes**, you may dilate my eyes today, if the doctor recommends it.

☐ **No**, I do not want my eyes dilated though I realize that doctor may not be able to do a complete health check.

The email and phone number provided will only be used to contact you regarding appointments, recalls, orders and payments.

Your glasses prescription is guaranteed up to 30 days for the date glasses were first made or 6 months from original exam, whichever comes first. Between 6-12 months there will be a $40.00 office visit fee. After 12 months a new exam will be required.

I have read, understand and agree to the above statements.

_____ _____

Signature of Patient / Responsible Party Date