PATIENT REGISTRATION and HEALTH HISTORY FORM

Patient's Name_____

Parent or Responsible Person's Name_____
(if the patient is a child)

Mailing Address_____

_____

_____
(City) (State) (Zip)

Whom may we thank for referring you to us?

_____

Date_____

Age_____Birthdate _____

Home Tel. #_____

Cell Tel. #_____

Work Tel. #_____

Email _____

Occupation _____

If a student: Grade _____

School Name_____

What is your reason for seeking vision care at this time?_____

_____

WILL TODAY'S EXAMINATION BE PAID FOR BY: ***CIRCLE ONE:***

Cash Check Insurance Credit Card HMO Medicare Medicaid Other

Name of Insurance Carrier_____

Family Health History
(check those someone in your family has had)

____ Allergies
____ Asthma
____ Cancer
____ Diabetes
____ Drug sensitivity
____ Hay fever
____ Heart condition
____ High blood pressure
____ Migraine headaches
____ Skin conditions
____ Thyroid condition
____ Tuberculosis

____ Blindness
____ Cataracts
____ Glaucoma
____ Lazy Eye
____ Poor color vision
____ Retinal disease
____ Turned eye

Patient's Health History
(check those you have had)

____ Allergies
____ Asthma
____ Blackouts
____ Cancer
____ Diabetes
____ Drug sensitivity
____ Hay fever
____ Heart condition
____ Hepatitis
____ High blood pressure
____ HIV / Aids
____ Migraine headaches
____ Skin conditions
____ Thyroid condition
____ Tuberculosis

____ Blindness / Reduced vision
____ Cataracts
Glaucoma
____ Poor color vision
____ Retinal disease
____ Turned eye

Patient's Visual Symptoms
(check those you have had)

____Distance vision blurred
____Near vision blurred
____Discomfort at distant visual tasks (e.g., driving, movies)
____ Discomfort at near visual tasks (e.g., reading, sewing)
____Light sensitivity
____Double vision
____Occasional vision changes
____Temporary loss of vision
____See flashing lights
____See floaters or spots
____Eye strain
____Headaches
____Burning eyes
____Red eyes
____ Itching eyes
____Watering eyes
____Dry eye
____Twitching eyelid
____None, routine eye examination

(PLEASE COMPLETE THE BACK SIDE ALSO)

Explanation of health history, where necessary._____

Do you consider your health? Good_____Fair_____Poor_____.

Are you presently taking any medications or drugs? Yes_____No_____.

If yes, what drugs are you taking?_____

Are you allergic to any medications? Yes_____No_____. If yes, which? _____

Have you ever had any serious eye disease, eye injury, or eye surgery? Yes_____No _____

If yes, please explain _____

When was your last eye examination? _____

What is your previous eye doctor's name? _____

When was your last visit to your physician? _____

What is your physician's name? _____

Do you wear contact lenses? Yes_____No_____. If yes, which type? hard_____soft_____

Additional Comments: _____

Authorization for treatment_____