



Patient Registration and Medical History Form

Patient Name: _____ Male / Female
first/middle initial/last preferred/nickname

Date of Birth: _____ Email address: _____

Address: _____
street city/state ZIP

Phone Numbers: _____ / _____ / _____
Home Work Cell (text messages? YES / NO)

Employer/Occupation: _____ Primary Care Physician/Clinic: _____

Vision Insurance: _____ Medical Insurance: _____
(A copy of all insurance cards is required on the day of service)

Eye and Vision History

Do you currently wear GLASSES? YES / NO If yes, Do you wear them for: DRIVING / READING / BOTH

Do you currently wear CONTACT LENSES? YES / NO If yes, Do you wear them overnight? YES / NO

If NO, Do you have an interest in starting or restarting contact lens wear? YES / NO

Are you interested in learning more about advances in contact lens technology? YES / NO

Do you have a history of previous eye surgeries or serious injury or infection in the eye? YES / NO

If YES, please explain: _____

Are you CURRENTLY having any of the following problems with your eyes?

- | | | | |
|------------------|------------|----------------------|-------------------------|
| Blurred Vision | Eye Strain | Dryness | Sensitivity to sunlight |
| Glare | Burning | Gritty/Sandy feeling | Redness |
| Flashes of light | Floaters | Itchy eyes | Watery eyes |

In an average day, Do you spend time reading, working on a computer, or completing other near work? YES / NO

Type of near work? READING COMPUTER NEEDLE WORK Other: _____

Are you interested in learning more about vision correction surgery (LASIK/PRK)? YES / NO

Are you interested in having longer and thicker eyelashes? YES / NO

Medications

Please list ALL medications that you are currently taking (including birth control, aspirin and eye drops):

Do you have any MEDICATION allergies? NO / YES: _____

Health History

General Health		Stomach/Digestive	
Developmental disability	Y / N	Colitis	Y / N
Fatigue Syndrome	Y / N	Ulcer	Y / N
Cancer	Y / N	Chron's	Y / N
Pregnant	Y / N	Other _____	
Breast feeding	Y / N	Urinary/Genital	
Other _____		STD	Y / N
Ears/Nose/Throat		Kidney Disease	Y / N
Sinusitis	Y / N	Prostate Disease	Y / N
Hearing Loss	Y / N	Other _____	
Dry Mouth	Y / N	Muscles/Joints	
Laryngitis	Y / N	Fibromyalgia	Y / N
Other _____		Arthritis	Y / N
Neurological		Osteoarthritis	Y / N
Multiple Sclerosis	Y / N	Muscular Dystrophy	Y / N
Cerebral Palsy	Y / N	Ankylosing Spondylitis	Y / N
Tumor	Y / N	Other _____	
Epilepsy	Y / N	Skin	
Other _____		Rosacea	Y / N
Psychiatric		Eczema	Y / N
Depression	Y / N	Psoriasis	Y / N
Other _____		Other _____	
Heart/Vascular		Endocrine	
Stroke	Y / N	Hormone Dysfunction	Y / N
Vascular Disease	Y / N	Diabetes – Insulin	Y / N
Heart Failure	Y / N	Diabetes – Non-Insulin	Y / N
Heart Disease	Y / N	Thyroid	Y / N
High Blood pressure	Y / N	Other _____	
Other _____		Blood	
Respiratory		Cholesterol	Y / N
Cigarette Smoker	Y / N	Blood loss	Y / N
COPD	Y / N	Anemia	Y / N
Bronchitis	Y / N	Other _____	
Asthma	Y / N	Allergy/Immunity	
Emphysema	Y / N	Rheumatoid Arthritis	Y / N
Other _____		Environmental	Y / N
		Other _____	

Social History

What HOBBIES / ACTIVITIES are you involved in? _____

Do you participate in OUTDOOR ACTIVITIES? BOATING/FISHING GARDENING SPORTS: _____

Do you drink alcohol? NO / YES: _____ drinks per week

Do you smoke tobacco? NO / YES: _____ cigarettes per day

Family History

Marital status: MARRIED SINGLE Do you have children at home? YES / NO

Has anyone in your family been diagnosed with any of the following HEALTH problems?

Diabetes High Blood Pressure Cancer Other: _____

Has anyone in your family been diagnoses with any of the following EYE problems?

Glaucoma Amblyopia (lazy eye) Cataracts Strabismus (eye turn) Macular Degeneration