

PATIENT REGISTRATION AND HEALTH HISTORY FORM

Date: _____
Patient Name Last _____ First _____ MI _____
Parent or Guardian _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Mobile _____
Work Phone _____ Work Ext. _____
Employer _____
Birth Date _____ Age _____
Social Security # _____
E-mail Address _____

METHOD OF PAYMENT: Cash _____ Check _____ Visa/MC _____ Medicaid _____ Medicare _____ Other Ins. _____

PLEASE GIVE RECEPTIONIST INSURANCE CARD BEFORE EXAM

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

VISUAL SYMPTOMS

_____ None, Periodic Eye Exam
_____ Distance Blurred
_____ Near Blurred
_____ Eyestrain
_____ Light Sensitivity
_____ Double Vision
_____ Loss of Vision
_____ Flashing Lights
_____ Floaters or Spots
_____ Headaches (eye)
_____ Burning Eyes
_____ Red Eyes
_____ Itching Eyes
_____ Watering Eyes
_____ Dry Eyes
_____ Injury to Eye(s)
_____ Variable Vision
_____ Twitching Eyelids

PATIENT'S HEALTH HISTORY

_____ Allergies
_____ Asthma
_____ Blackouts
_____ Cancer
_____ Diabetes
_____ Hay Fever/Sinus
_____ Heart Condition
_____ High Blood Pressure
_____ Skin Condition
_____ Thyroid Condition
_____ Migraines
_____ Cataracts
_____ Glaucoma
_____ Lazy Eye
_____ Poor Color Vision
_____ Turned Eye
_____ Arthritis
_____ Other

FAMILY HEALTH HISTORY

_____ Allergies
_____ Cancer
_____ Diabetes
_____ Heart Condition
_____ High Blood Pressure
_____ Thyroid Condition
_____ Migraines
_____ Blindness
_____ Cataracts
_____ Glaucoma
_____ Lazy Eye
_____ Poor Color Vision
_____ Turned Eye

When was your last eye exam? _____ By Whom? _____

Have you ever had any serious eye disease, injury, or surgery? Yes No

If Yes, please explain: _____

Last Medical Exam? _____

Are you presently taking any medications/drugs? Yes No

If yes, what medications? _____

Are you allergic to any medications? Yes No

If Yes, please explain: _____

Do you have or have you ever worn contact lenses? Yes No

If Yes, what type? _____ Soft _____ Toric _____ Gas Permeable

When was your husband/wife last examined? _____ By Whom? _____

When were your children last examined? _____ By Whom? _____

Whom may we thank for referring you to us: _____
