

# 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: \_\_\_\_\_  
\_\_\_\_\_