

**Patient Registration and Health History**

Date: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Parent's Name (If patient is a minor): \_\_\_\_\_ If a student, Grade: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Type:  Cell  Home Emergency Contact Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Have you had your eye exam at this office before?:  Yes  No

What is the reason for seeking vision care at this time?: \_\_\_\_\_

If using insurance, patient's relationship to insured:  Self  Spouse  Dependent

Primary Insured's Name: \_\_\_\_\_ Primary Insured's Date of Birth: \_\_\_\_\_

Primary Insured's Employer: \_\_\_\_\_ Member ID: \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_ Auth. No.: \_\_\_\_\_

How did you hear about us?  Yelp  Google Referral: \_\_\_\_\_ Other: \_\_\_\_\_

Please check this box if there have been no changes to your medical and ocular history since your last visit at this office.

Do you consider your health:  Good  Fair  Poor

<p><b>Patient's Visual Symptoms</b> (check each you have had)</p> <p><input type="checkbox"/> None/Routine Eye Exam <input type="checkbox"/> Itching eyes  <input type="checkbox"/> Blurred Distance Vision <input type="checkbox"/> Eye strain  <input type="checkbox"/> Blurred Near Vision <input type="checkbox"/> Red eyes  <input type="checkbox"/> Burning Eyes <input type="checkbox"/> Flashing lights  <input type="checkbox"/> Discomfort at near tasks <input type="checkbox"/> Floaters/Spots  <input type="checkbox"/> Temporary Loss of Vision <input type="checkbox"/> Watery eyes  <input type="checkbox"/> Twitching eyelids <input type="checkbox"/> Dry eyes  <input type="checkbox"/> Light Sensitivity <input type="checkbox"/> Variable vision  <input type="checkbox"/> Headaches related to eyes <input type="checkbox"/> Other: _____</p>	<p><b>Patient's Health History</b> (check each you have had)</p> <p><input type="checkbox"/> None <input type="checkbox"/> Migraine/HA  <input type="checkbox"/> Diabetes <input type="checkbox"/> Skin conditions  <input type="checkbox"/> High blood pressure <input type="checkbox"/> Drug sensitivity  <input type="checkbox"/> Heart condition <input type="checkbox"/> Cataracts  <input type="checkbox"/> Cholesterol <input type="checkbox"/> Glaucoma  <input type="checkbox"/> Cancer <input type="checkbox"/> Macular degeneration  <input type="checkbox"/> Asthma <input type="checkbox"/> Lazy eye (amblyopia)  <input type="checkbox"/> Allergies <input type="checkbox"/> Poor color vision  <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Blindness  <input type="checkbox"/> Thyroid condition <input type="checkbox"/> Other: _____  <input type="checkbox"/> Blackouts _____</p>	<p><b>Family Health History</b> (check each if someone in family has had)</p> <p><input type="checkbox"/> None <input type="checkbox"/> Migraine/HA  <input type="checkbox"/> Diabetes <input type="checkbox"/> Skin conditions  <input type="checkbox"/> High blood pressure <input type="checkbox"/> Drug sensitivity  <input type="checkbox"/> Heart condition <input type="checkbox"/> Cataracts  <input type="checkbox"/> Cholesterol <input type="checkbox"/> Glaucoma  <input type="checkbox"/> Cancer <input type="checkbox"/> Macular degeneration  <input type="checkbox"/> Asthma <input type="checkbox"/> Lazy eye (amblyopia)  <input type="checkbox"/> Allergies <input type="checkbox"/> Poor color vision  <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Blindness  <input type="checkbox"/> Thyroid condition <input type="checkbox"/> Other: _____  <input type="checkbox"/> Blackouts _____</p>
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When was your last eye exam? \_\_\_\_\_ What is your previous eye doctor's name? \_\_\_\_\_

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

If yes, please explain: \_\_\_\_\_

Do you wear contact lenses?  Yes  No

If yes, which type?  Hard  Soft

When was your last visit to your medical physician? \_\_\_\_\_ What is your medical physician's name? \_\_\_\_\_

**For Women:** Are you pregnant?  Yes  No Are you breastfeeding?  Yes  No

Do you smoke, consume alcohol, or use recreational drugs?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you presently taking any medication or drugs?  Yes  No

If yes, what drugs are you taking? \_\_\_\_\_

Are you allergic to any medications?  Yes  No

If yes, which? \_\_\_\_\_

**Signature:** \_\_\_\_\_