Patient Registration and Health History

In order to give you the best possible care, please take the time to completely fill out both sides of this form

Name _____ Today's Date _____

Street _____ Birth Date _____

City _____ State _____ Zip _____ Home Tel (_____)_____

Occupation _____ Work or Cell Tel (_____)_____

Vision Ins: _____ ACCT#:_____ Email Address: _____

Medical Ins: _____ ACCT#: _____ Primary Member: _____ D.O.B.:___/___/____

Date of last physical exam _____ Date of last eye exam _____

Do you wear contact lenses? ☐ Yes ☐ No Brand/Type: _____ Was a dilation performed? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No Do you use a computer? ☐ Yes ☐ No

Are you sensitive to light or glare? ☐ Yes ☐ No Are you pregnant or nursing? ☐ Yes ☐ No

If you were glasses, please check the types of glasses that you use:

☐ Distance (driving, etc.) ☐ Near (reading, etc.) ☐ Computer ☐ Sunglasses
☐ Bifocals ☐ Progressives ☐ Sports goggles ☐ Polarized glasses
☐ List any other _____

Please check any of the following symptoms that you experience:

☐ Blurred distance vision ☐ Blurred near vision ☐ Eyestrain ☐ Double vision
☐ Tearing ☐ Itching ☐ Frequent headaches ☐ Eye pain
☐ Burning eyes ☐ Sensitive to light ☐ Spots / floaters ☐ Flashes of light
☐ Red Eyes ☐ Dry Eyes ☐ Night Vision Difficulty ☐ List any other _____

Please check any of the following hobbies or recreational activities:

☐ Boating/Fishing ☐ Photography ☐ Computer ☐ Flying/Pilot
☐ Music ☐ Swimming ☐ Golf ☐ Shooting/Hunting
☐ List any other _____

HIPAA PRIVACY

I understand that the Location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/ or type of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services and products, process my vision and/or medical benefits claims and communicate with me regarding vision and/or medical care services provided by the Location.

I can be assured that this Location does not sell my personal health information of any kind to a third party for such party's own use. I acknowledge and agree that the Location may submit my vision and/or medical benefits claims to my plan sponsor or health plan to receive reimbursement directly for the vision and/or medical services and products that I have received from the Location.

_____ _____
Patient Signature or Patient's Legal Representative Date

PLEASE TURN OVER AND COMPLETE OTHER SIDE ➡

LAST NAME:_____ FIRST NAME:_____ DATE OF BIRTH:_____

Do you presently have any problems in the following areas? If "YES," please give an explanation. If no, please circle N.

Constitutional
Fever Y N _____
Weight loss Y N _____
Malaise Y N _____
Fatigue Y N _____

Ears, Nose, Mouth, Throat
Sinus Congestion Y N _____
Chronic Cough Y N _____
Dry Mouth/Throat Y N _____
Decreased Hearing Y N _____
Difficulty Swallowing Y N _____

Cardiovascular
High Blood Pressure Y N _____
Heart Attack/Angina Y N _____
Arrhythmia Y N _____
Heart Failure/Block Y N _____
High Cholesterol Y N _____

Respiratory
Shortness of Breath Y N _____
Wheezing Y N _____

Musculoskeletal
Muscle Pain/Weakness Y N _____
Joint Pain Y N _____

Integument
Chronic Rash Y N _____
Changing Growth Y N _____
Skin Cancer Y N _____
Breast Cancer Y N _____

Gastrointestinal
Ulcers Y N _____
Gastritis Y N _____

Genitourinary
Kidney Stones Y N _____
Prostate Enlargement Y N _____

Neurological
Stroke Y N _____
TIA Y N _____
Headaches Y N _____
Psychiatric (depression) Y N _____

Endocrine
Thyroid disease Y N _____
Pituitary Y N _____
Diabetes Y N _____
Menstrual Abnormalities Y N _____

Hematologic/Lymphatic
Bleeding Disorder Y N _____
Lymphoma/Leukemia Y N _____

Allergic/Immunologic
Asthma Y N _____
Seasonal Allergies Y N _____
Lupus Y N _____
Rheumatoid Arthritis Y N _____

Other symptoms not noted above Y N
_____
_____

FAMILY HISTORY
Did/does someone in your family have:

Macular Degeneration Y N _____
Cataracts Y N _____
Glaucoma Y N _____
Diabetes Y N _____
Cancer Y N _____
Heart Attack Y N _____
Stroke Y N _____
Other Y N _____

SOCIAL HISTORY
Do you work? (list job) Y N _____

Do you drink alcohol? Y N _____
If yes, how many glasses a day

Do you smoke? Y N Quit

If yes, how many packs a day and for how long
_____

PAST HISTORY (complete each line)
List all medications you take None _____
List all eye medications you take None _____
List all medical illnesses and injuries None/ SEE ABOVE _____
List any surgeries you have had None _____
Do you have any allergies to medications Y N List _____

_____ _____
PHYSICIAN SIGNATURE **DATE**