PATIENT REGISTRATION & MEDICAL HISTORY

Last Name _____ First Name _____ M.I. _____ Preferred Name_____

Mailing Address _____ City _____ State_____ Zip Code_____

Marital Status S M W D O Birth Date _____ Age _____ Social Security # _____

Home Phone _____ Cell Phone _____ E-mail Address_____

Employer_____ Occupation _____

Referred By _____ Family Physician _____

Previous Eye Doctor _____

IF MINOR: Mother's Name _____ Father's Name _____

Insurance Information

Do you have vision insurance? ◯ Yes ◯ No Do you have health insurance? ◯ Yes ◯ No

Vision Insurance _____ Policy Holder _____ DOB_____

Primary Insurance _____ Policy Holder _____ DOB _____

Secondary Insurance_____ Policy Holder _____ DOB _____

Relationship to Policy Holder _____ Policy Holder's Social Security# _____

Medications

List any medications or eye drops you are allergic to _____

List current medications (Prescription or Over-the Counter) _____

_____

☐ See Attached List

Health & History

Your Health

Have you ever had or do you have….

- ◯ Allergies
- ◯ Auto Immune Disorder
- ◯ Diabetes
- ◯ Cancer
- ◯ Headaches
- ◯ Drug Reaction
- ◯ Heart Disease
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ Thyroid Disease
- ◯ Eye Surgery_____
- ◯ Glaucoma
- ◯ Macular Degeneration
- ◯ Other _____
- ◯ None of the Above

Family History

Has anyone in your family ever had

- ◯ Diabetes
- ◯ Glaucoma
- ◯ Blindness
- ◯ Cataracts
- ◯ Lazy Eye
- ◯ Macular Degeneration
- ◯ Other
- ◯ None of the Above

Vision Needs

Do you do the following?

- ◯ Fishing
- ◯ Crafts/Sewing
- ◯ Gardening
- ◯ Computer
- ◯ Read Books
- ◯ Golf
- ◯ Team Sports
- ◯ Music
- ◯ Shooting
- ◯ Racquet Ball
- ◯ Skiing
- ◯ Welding
- ◯ Woodshop
- ◯ Water Sports
- ◯ Other _____
- ◯ None of the Above

Social History

Do you…

- ◯ Smoke
- ◯ Consume Alcohol
- ◯ Use Street Drugs
- ◯ None of the Above

PATIENT SIGNATURE _____ **DATE** _____