PATIENT REGISTRATION AND HEALTH HISTORY FORM

Patient's Name ______________________________

Parent or Responsible
Person's Name ______________________________
(If the patient is a child)

Mailing Address ______________________________

____

____
(City) (State) (Zip)

Whom may we thank for referring you to us?

____

Date ______________________________

Age ____________ Birthdate ______________

Home Tel. # ______________________________

Work Tel. # ______________________________

Occupation ______________________________

Employer ______________________________

If a student: Grade ______________________________

School Name ______________________________

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

____

WILL TODAY'S EXAMINATION BE PAID FOR BY: ***CIRCLE ONE:***

Cash **Check** **Insurance** **Credit Card** **HMO** **Medicare** **Medicaid** **Other**

Name of Insurance Carrier? ______________________________

Family Health History

(check those someone in your family has had)

____ Allergies
____ Asthma
____ Cancer
____ Diabetes
____ Drug sensitivity
____ Hay fever
____ Heart condition
____ High blood pressure
____ Migraine headaches
____ Skin conditions
____ Thyroid condition
____ Tuberculosis

____ Blindness
____ Cataracts
____ Glaucoma
____ Lazy eye
____ Poor color vision
____ Retinal Disease
____ Turned Eye

Patient's Health History

(check those you have had)

____ Allergies
____ Asthma
____ Blackouts
____ Cancer
____ Diabetes
____ Drug sensitivity
____ Hay Fever
____ Heart condition
____ Hepatitis
____ High blood pressure
____ HIV / Aids
____ Migraine headaches
____ Skin conditions
____ Thyroid condition
____ Tuberculosis

____ Blindness/Reduced Vision
____ Cataracts
____ Glaucoma
____ Poor color vision
____ Retinal disease
____ Turned eye

Patient's Visual Symptoms

(check those you have had)

____ Distance vision blurred
____ Near vision blurred
____ Discomfort at distant visual tasks
____ (e.g. driving, movies)
____ Discomfort at near visual tasks
____ (e.g. reading, sewing)
____ Light sensitivity
____ Double vision
____ Occasional vision changes
____ Temporary loss of vision
____ See flashing lights
____ See floaters or spots
____ Eye strain
____ Headaches
____ Burning eyes
____ Red eyes
____ Itching eyes
____ Watering eyes
____ Dry eye
____ Twitching eyelid
____ None, routine eye examination

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