PATIENT REGISTRATION AND HEALTH HISTORY FORM

Patient's Name_____ Date:_____

Address_____City/State_____Zip _____

Home phone #_____Cell/ Work#_____ Age _____Birthdate _____

If Student: Grade _____ School:_____ Email Address:_____

Occupation _____Employer _____

Person responsible for payment_____ Name of Insurance _____
(Parent or Guardian) (If Applicable)

Reason for your visit today? _____

Family History		Patient's History		Patient's Symptoms	
_____	Allergies	_____		_____	Distance Blurred Vision
_____	Asthma	_____		_____	Near Blurred Vision
_____	Cancer	_____		_____	Discomfort at distant visual tasks (e.g. driving, movies)
_____	Diabetes	_____		_____	Discomfort at near visual tasks (e.g. reading, sewing)
_____	Drug Sensitivity	_____		_____	Light Sensitivity
_____	Hay Fever	_____		_____	Double Vision
_____	Heart condition	_____		_____	Occasional vision changes
_____	High Blood Press.	_____		_____	Temporary Loss of Vision
_____	Migraine Headaches	_____		_____	Flashing Lights
_____	Skin conditions	_____		_____	Floaters or spots
_____	Tuberculosis	_____		_____	Eye Strain
_____	Blindness/Reduced Vision	_____		_____	Headaches
_____	Cataracts	_____		_____	Burning Eyes
_____	Glaucoma	_____		_____	Red Eyes
_____	Lazy Eye	_____		_____	Itching Eyes
_____	Turned Eye	_____		_____	Watering Eyes
_____	Poor Color Vision	_____		_____	Dry Eye
_____	Retinal Disease	_____		_____	Twitching Eyelids
N/A	Blackouts	_____		_____	None, routine eye examination
N/A	Hepatitis	_____			
N/A	HIV/ AIDS	_____			
N/A	Thyroid conditions	_____			

When was your last eye examination? _____ Dr.'s name ?_____

When was your last visit to your physician ? _____Dr.'s name ?_____

Do you consider your health? Good ____ Fair ____ Poor ____

Medications you are taking? _____

Medications you are allergic to ? _____

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

If yes, please explain_____

Do you wear contacts ? Yes ___No___ Contact Type ? Soft _____Hard _____

Authorization for treatment _____
(Patient Signature or Patient's Legal Representative)