Registration Form

History Form

1. Demographics

First Name of the Patient:
-

Last Name
-

Middle Initial of the Patient:
-

Preferred Name:
-

Gender
-

Pronoun Pref.
-

Street Address:
-

Street Address 2:
-

City:
-

State:
-

ZIP Code:
-

Social Security Number:
-

Home Phone:
-

Cell Phone:
-

Email:
-

Communication Pref.

☐ Phone ☐ Text ☐ Email

Date of Birth:
-

Height:
-

Weight:
-

Race

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hispanic

☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

2. Patient Employer (or School):
-

Patient Occupation (or Grade):
-

Spouse/Partner:
-

Spouse/Partner Phone #:
-

Parent (if under 18):
-

Person responsible for account (if not patient):
-

Relationship to patient:
-

3. Insurance

Primary Insurance Company:
-

Member ID / Policy #:
-

Relationship to Insured
-

If Other, Please specify:
-

Insured Name:
-

Insured Date of Birth:
-

Secondary Insurance Company:
-

Member ID / Policy #:
-

Relationship to Insured
-

If Other, Please specify:
-

Insured Name:
-

Insured Date of Birth:
-

4. Name of Medical Doctor:
-

Date of last Physical Exam:
-

Name of Diabetes Doctor (if applicable, and if different from above)
-

5. Personal Review of Symptoms

Cardiovascular

- [ ] Heart Disease
- [ ] High Cholesterol
- [ ] High Blood Pressure
- [ ] Other

Constitutional

- [ ] Anemia
- [ ] Excessive Hunger/Thirst/ Urination
- [ ] Fever
- [ ] Other

Endocrine

- [ ] Type 1 Diabetes
- [ ] Type 2 Diabetes
- [ ] Gout
- [ ] Hyperthyroid
- [ ] Hypothyroid
- [ ] Other

Gastrointestinal

- [ ] Constipation
- [ ] Diarrhea
- [ ] Stomach
- [ ] Ulcer
- [ ] Other

Genitourinary

- [ ] Bladder/ Kidney Infection
- [ ] Menopause
- [ ] STD
- [ ] Other

Hematologic/ Lymphatic

- [ ] Bleeding Disorder
- [ ] Sickle Cell Disease
- [ ] Other

Immunologic

- [ ] AIDS/ HIV
- [ ] Herpes Zoster (Shingles)
- [ ] Other

Integumentary

- [ ] Rosacea
- [ ] Skin Cancer
- [ ] Other

Musculoskeletal

- [ ] Arthritis
- [ ] Osteoporosis
- [ ] Other

Neurological

- [ ] Headaches
- [ ] Multiple Sclerosis
- [ ] Seizures
- [ ] Other

Psychiatric

- [ ] Anxiety
- [ ] Depression
- [ ] Other

Respiratory

- [ ] Asthma
- [ ] Chronic Bronchitis
- [ ] Emphysema
- [ ] Other

6. Personal Medical History

Previous injuries, surgeries, and/or infections
-

Have you ever had a concussion or brain injury? If so, when?
-

Medications: (including over-the-counter)
-

Medication Allergies:
-

Other Allergies:
-

Are you currently pregnant?
-

If yes, how many weeks?
-

Are you currently nursing?
-

7. Personal Ocular History

Previous injuries, surgeries, and/or infections:
-

Do you experience fluctuating vision?
-

Do you experience burning, redness or irritation?
-

Do you experience double vision or close one eye while reading?
-

Are you concerned about wrinkles around your eyes?
-

How many hours a day do you look at electronic screens (including your phone)?
-

Ocular Medications: (including over-the-counter)
-

Date of Last Eye Exam:
-

Examining Doctor:
-

8. Social History

Use of Alcohol
-

Frequency of Alcohol Use:
-

Use of recreational drugs:
-

Use of Tobacco
-

If former smoker, when did you quit?
-

If current smoker, quantity?
-

9. Current Glasses wearer?
-

If yes, when do you wear glasses?

☐ Full time ☐ Distance only ☐ Computer only ☐ Reading only

Current Contact Lens wearer?
-

Brand of contacts:
-

Power: Right Eye
-

Power: Left Eye
-

10. Ocular Family History

Blindness
-

Relationship to you:
-

Cataracts
-

Relationship to you:
-

Glaucoma
-

Relationship to you:
-

Lazy Eye
-

Relationship to you:
-

Macular Degeneration
-

Relationship to you:
-

Retinal Detachment
-

Relationship to you:
-

Other:
-

11. Systemic Family History

Arthritis
-

Relationship to you:
-

Cancer
-

Relationship to you:
-

Type 1 Diabetes
-

Relationship to you:
-

Type 2 Diabetes
-

Relationship to you:
-

Heart Disease
-

Relationship to you:
-

High Cholesterol
-

Relationship to you:
-

High Blood Pressure
-

Relationship to you:
-

Thyroid Disease
-

Relationship to you:
-

Other:
-

12. Additional Information

Reason for your visit today (i.e.: new glasses/contact lenses, LASIK evaluation, dry eye – gritty/sandy/burning/tired feeling – red eye, flashes/floaters, eye pain or discharge, etc.)
-

Please list any visual needs relating to your occupation, recreation, or hobbies:
-

How did you find out about our office?
-