PATIENT REGISTRATION

Bring this form filled out along with your medical insurance card to your appointment.

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your vision is our vision

❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr.

First Name: _____ Middle Int: _____ Last Name: _____

Nickname: _____ DOB: _____ SS#: _____ ❍ Male ❍ Female

Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone#: _____ Secondary#: _____ Third#: _____

Email: _____ Marital Status: ❍ Single ❍ Married ❍ Divorced ❍ Widowed

Insurance Provider: _____

Member Name *(if different than patient)*: _____

Relationship to Patient: _____ SS#: _____

DOB: _____ Member Address: _____

Guarantor for Minor or POA: _____ Relationship: _____

Guarantor Address: _____ Phone: _____

Guarantor SS#: _____ DOB: _____

Primary Care Physician: _____

Address: _____

Referred By: _____

Emergency Contact: _____ Phone: _____

Nearest Relative *(not living with you)*: _____ Phone: _____

List the person(s) who may have access to your medical records: _____

Are you currently in a Skilled Nursing Facility? ❍ YES ❍ NO

Name of Facility: _____

Address: _____ Phone: _____

MEDICAL HISTORY QUESTIONNAIRE

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Name: _____ DOB: _____

Referrig Doctor: _____ Primary Care Physician: _____

Pharmacy Name & Location (street & city): _____

_____

Race: _____ Preferred Language: _____

Please List Clinically Significant Allergies: _____

_____

Past Ocular History (please mark all that apply):

- ❍ Amblyopia (lazy eye)
- ❍ Astigmatism
- ❍ Cataracts
- ❍ Corneal Disorder
- ❍ Diabetic Retinopathy
- ❍ Dry Eye Syndrome
- ❍ Glaucoma
- ❍ Hyperopia (farsighted)
- ❍ Iritis/Uveitis
- ❍ Macular Degeneration
- ❍ Myopia (nearsighted)
- ❍ Retinal Detachment/Tear
- ❍ Occlusion
- ❍ Blepharitis
- ❍ Chalazion
- ❍ Eye Lid Lesion
- ❍ Other: _____

Ocular Surgeries (please mark all that apply):

Cornea	Lid	Lens	Retina	Glaucoma
❍ LASIK	❍ Blepharoplasty	❍ Cataract Extraction	❍ Vitrectomy	❍ Stent/Shunt
❍ PRK	❍ Lesion Removal	❍ Lens Exchange	❍ Laser	❍ Bleb/Trab
❍ SK	Muscle	❍ YAG	❍ Detatchment/Tear	❍ SLT
❍ Transplant	❍ Strabismus			❍ LPI

Other: _____

Other Medical History: ❍ No History of Illnesses

- ❍ Anemia
- ❍ Arthritis
- ❍ Arrhythmia
- ❍ Asthma
- ❍ Cancer
- ❍ Congestive Heart Failure
- ❍ COPD
- ❍ HIV/AIDS
- ❍ Fibromyalgia
- ❍ Headache
- ❍ Hearing Loss
- ❍ Heart Attack
- ❍ Hepatitis
- ❍ Herpes
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Stroke
- ❍ Kidney Disease
- ❍ Liver Disease
- ❍ Lupus
- ❍ Migraine
- ❍ Multiple Sclerosis
- ❍ Polymyalgia Rheumatica
- ❍ Psychiatric Disorder
- ❍ Rheumatoid Arthritis
- ❍ Thyroid Disease
- ❍ Diabetes
  - Type: _____
  - Insulin Use: _____
  - Year Diagnosed: _____
- ❍ Other: _____

General Surgeries/Procedures (please list): ❍ None

_____

Eye Medications (please list): _____

_____

_____

All Other Medications (please list): _____

_____

_____

continued on back →

Family History: ❍ None/Unknown

❍ Blindness
❍ Cancer
❍ Cataracts
❍ Diabetes
❍ Glaucoma
❍ Heart Disease
❍ High Blood Pressure
❍ Lazy Eye
❍ Macular Degeneration
❍ Retinal Disease
❍ Stroke
❍ Other: _____

Social History (please mark all that apply):

Smoking: ❍ Every day ❍ Some days ❍ Former ❍ Never

Alcohol Use: ❍ No ❍ Yes, amount/frequency/length? _____

Drug Use: ❍ No ❍ Yes, amount/frequency/length? _____

Review of Systems (please mark all that apply):

Eyes
❍ Previous Surgery
❍ Contact Lens
❍ Pain
❍ Double Vision
❍ Glaucoma
❍ Cataracts
❍ Macular Degeneration
❍ Dry Eyes
❍ Flashes
❍ Floaters

Ear, Nose, & Throat
❍ Hard of Hearing
❍ Ringing in Ears
❍ Vertigo

Cardiovascular
❍ Chest Pain
❍ Dizziness
❍ Fainting Spells
❍ Shortness of Breath
❍ Irregular Heart Beat
❍ Difficulty Lying Flat

Constitutional
❍ Fatigue/Weakness
❍ Fever
❍ Weight Gain/Loss

Respiratory
❍ Cough
❍ Congestion
❍ Wheezing
❍ Asthma

Gastrointestinal
❍ Heartburn
❍ Nausea/Vomiting
❍ Jaundice/Hepatitis

Psychiatric
❍ Anxiety/Depression
❍ Mood Swings
❍ Difficulty Sleeping

Endocrine
❍ Increased Thirst
❍ Increased Hunger
❍ Increased Urination
❍ Increased Sweating
❍ Fingernail Changes

Blood/Lymph Nodes
❍ Easy Bruising
❍ Prolonged Bleeding
❍ Heavy Aspirin Use

Musculoskeletal
❍ Stiffness
❍ Arthritis
❍ Joint Pain/Swelling

Skin
❍ Rash/Sores
❍ Lesions
❍ Hives/Eczema
❍ Psoriasis

Neurological
❍ Seizures
❍ Weakness/Paralysis
❍ Numbness
❍ Tremors

Immunologic
❍ Hives
❍ Itching
❍ Runny Nose
❍ Sinus Pressure

Specific Medication:

❍ Acutane (former/current)
❍ Flomax (former/current)
❍ Amiodarone (former/current)
❍ Tamsulosin (former/current)
❍ Saxenda (former/current)
❍ Semaglutide (former/current)
❍ Adlyxin (former/current)
❍ Bydureon (former/current)
❍ Byetta (former/current)
❍ Monjaro (former/current)
❍ Tanzeum (former/current)
❍ Trulicity (former/current)
❍ Ozempic (former/current)
❍ Rybelsus (former/current)
❍ Wegovy (former/current)
❍ Victoza (former/current)
❍ Plaquenil (former/current)
Started: _____ End: _____
Dose: _____

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Reviewed By/On: _____