Patient Registration

Name: ______________________________ Date: ______________

Address: ______________________________ Phone: ______________
City:______________ State:_______ Zip: __________ Cell Phone: ______________

Birth Date: ______________ Occupation and Employer:______________________________

Guardian or Spouse:______________________ Name of Medical Doctor: ______________________

Reason for today's visit: ______________________ Email: ______________________

Eye Health History
Last Eye Exam: ____________ Do you wear glasses? Y N Contacts? Y N What Brand? ______________

Do you have or have you had any of the following?

Crossed or Lazy Eye	Y N	Cataracts	Y N	Eye Surgeries	Y N
Flashes or Floaters	Y N	Glaucoma	Y N	If yes, please explain	______________
Dry Eyes	Y N	Double Vision	Y N	______________________	

Medical History and Review of Systems
List any medications you take: ____
____
____
List any allergies you have: ____
List any major injuries, surgeries, or conditions you have: ______________________
____
Are you pregnant or breast feeding? Y N

General:		**Bones, Joints, Muscles:**		**Constitutional:**	
Fever, Weight Loss/Gain	Y N	Rheumatiod Arthritis	Y N	Dizziness	Y N
Neurological:		Muscle Pain	Y N	Motion Sickness	Y N
Headaches	Y N	**Skin:**		**Vascular:**	
Migranes	Y N	Acne Rosecea	Y N	Hypertension	Y N
Seizures	Y N	Eczema	Y N	Heart attack	Y N
Ear, Nose, Throat:		Skin Cancer	Y N	Stroke	Y N
Allergies/ Hayfever	Y N	**Hematologic:**		**Endocrine:**	
Sinus Congestion	Y N	Anemia	Y N	Thyroid disorder	Y N
Chronic Cough	Y N	Bleeding problems	Y N	Diabetes	Y N
Hearing Loss	Y N	**Gastrointestinal:**		**Respiratory:**	
Immunological:		Ulcers	Y N	Asthma	Y N
AIDS/HIV	Y N	Hepatitis	Y N	Emphysema	Y N

Family History
Please note any family history for the following conditions:

Glaucoma	Y N	Blindness	Y N	Hypertension	Y N
Macular Degeneration	Y N	Heart Disease	Y N	Diabetes	Y N

Social History
Do you drive? Y N If yes, do you have visual difficulty when driving ?______________________
Do you use tobacco products? Y N Alcohol? Y N Recreational Drugs? Y N

Preferred Language:______________ Race:____________ Ethnicity: Hispanic Non Hispanic Pacific Islander
Communication Preference: Mail Email Telephone (Please circle one)
Who may we thank for referring you? ______________________
I have read and understand the HIPAA Notice of Privacy.

______________________________ ______________
Patient's Signature Date

______________________________ ______________
Doctor's Signature Date