

ADULT PATIENT HISTORY & REGISTRATION

Welcome to our office! Please take a moment to fill out all of the following information to the best of your knowledge.

PERSONAL INFORMATION

Patient Name: _____		Sex: <input type="checkbox"/> F <input type="checkbox"/> M	DOB: ____ / ____ / ____	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
Patient Address: Street _____ Apt _____ City _____ State _____ Zip _____				
E-Mail Address: _____			Home Phone: () -	
Employer (if applicable): _____		Occupation: _____		Work Phone: () -
Pharmacy Name: _____ Pharmacy City: _____			Cell Phone: () -	

MEDICAL / SOCIAL HISTORY

Family Physician: _____	Phone: _____	Date of Last Physical Checkup: _____
Please list any medications you currently take (Rx and over-the-counter): _____		Please list any allergies to medications, if applicable: _____

Do you currently have any problems in the following areas?	Y	N	If yes, please explain:
GENERAL CONSTITUTIONAL: (fever, heat stroke, weight loss, weight gain, unusually tired)			
EYES: (poor vision, eye pain, tearing, redness, etc.)			
EARS, NOSE, THROAT: (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR: (high blood pressure, racing pulse, etc.)			
RESPIRATORY: (congestion, wheezing, shortness of breath, etc.)			
GASTROINTESTINAL: (upset stomach, diarrhea, constipation, hernia, ulcers, etc.)			
SKIN: (pimples, warts, growths, rash, etc.)			
MUSCLES, BONES, JOINTS: (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
NEUROLOGICAL: (numbness, headache, seizures, paralysis, etc.)			
GENITAL, KIDNEY, BLADDER: (painful or frequent urination, impotence, yellow jaundice, etc.)			
BLOOD/LYMPH: (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC: (sneezing, swelling, redness, itching, hives, lupus, etc.)			
ENDOCRINE: (diabetes, hypothyroid, etc.)			
PSYCHIATRIC: (anxiety, depression, insomnia, etc.)			
FEMALES: Are you pregnant? Nursing?			

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? Yes No

Have you ever had a blood transfusion? Yes No

Do you drink alcohol? Yes No If Yes, how much? _____

Do you smoke? Yes No If Yes, how much? _____ How many years? _____

EYE HISTORY

Date of Last Eye Exam: _____	I wear my glasses for: <input type="checkbox"/> Computer <input type="checkbox"/> Reading <input type="checkbox"/> TV <input type="checkbox"/> School	I wear my contacts: _____ hrs/day
By Whom: _____		Brand: _____
Purpose of today's visit? _____		Type: _____

Have you ever been diagnosed or treated for the following? <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinal Detachment <input type="checkbox"/> Corneal Abrasion <input type="checkbox"/> Iritis/Uveitis <input type="checkbox"/> Retinal Disease <input type="checkbox"/> Eye infection <input type="checkbox"/> Lazy eye <input type="checkbox"/> Other eye disorders <input type="checkbox"/> Eye injury <input type="checkbox"/> Macular Degeneration _____	Do you experience any of the following symptoms with your current eyeglass prescription? <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Uncomfortable glasses <input type="checkbox"/> Burning <input type="checkbox"/> Floaters / Spots <input type="checkbox"/> Tearing <input type="checkbox"/> Grittiness <input type="checkbox"/> Headaches <input type="checkbox"/> Itchiness <input type="checkbox"/> Flash of light <input type="checkbox"/> Occasional dryness <input type="checkbox"/> Double vision <input type="checkbox"/> Sunlight sensitivity <input type="checkbox"/> Crossed eye/eye turn <input type="checkbox"/> Other: _____ <input type="checkbox"/> Trouble seeing at night _____
Do you have a blood relative with any of the above conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please list the conditions and relationship of relative) _____	

Please check all that apply. Do you...

<input type="checkbox"/> Wear bifocals? If YES, do the lines or head tilting both you? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Work at a computer? <input type="checkbox"/> Yes <input type="checkbox"/> No
If NO, would you like information on PROGRESSIVE lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Prefer not to wear your glasses at times? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Wear contact lenses? If YES, are you satisfied with the vision and comfort? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Want information on Laser Vision Correction surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
If NO, would you like information on contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Emergency Contact Name: _____ Relationship: _____ Phone: () -