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

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