PATIENT REGISTRATION

Name: _____ Date: _____

Title: (circle one) Mr. Mrs. Miss Ms. Dr.

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (H) _____ (W) _____ (Cell) _____

SSN (for insurance purposes only): _____ Date of Birth: _____

Occupation: _____ Employer: _____

School (if student): _____ Grade: _____

Name of Parent or Spouse: _____

Referred by: _____

Primary Physician: _____ Date of Last Visit: _____

Pharmacy Name: _____ Pharmacy phone # _____

IF Mail order pharmacy: Mail Order Pharmacy Name _____ Pharm ID # _____

Medical History

Medications: _____

Allergies (medication or environmental): _____

Surgeries (type and date): _____

Do you smoke? Y/N Packs/day ___ Former smoker? Y/N Do you drink alcohol? Y/N drinks/week ____

Please check if you have ever had or been treated for the following conditions:

( ) Heart Disease	( ) Respiratory (i.e. asthma)	( ) Cancer
( ) High Blood Pressure	( ) Kidney/Liver Disease	( ) Anemia
( ) High Cholesterol	( ) Thyroid Disease	( ) Stroke/Neurologic
( ) Diabetes	( ) Arthritis/Rheumatologic	( ) Headaches
( ) Other: _____		

Eye History

Please check if you have/have had any of the following conditions:

( ) Glaucoma	( ) Macular Degeneration	( ) Dry Eyes
( ) Cataracts	( ) Retinal Problems	( ) Other: _____

Family History

Please check if any member of your family has any of the following conditions:

( ) Heart Disease	( ) Macular Degeneration	( ) Cataracts
( ) High Blood Pressure	( ) Retinal Detachment	( ) Glaucoma
( ) Diabetes	( ) Cancer	( ) Other: _____

Do you have blurred vision? Y/N Distance blurry? Y/N Reading blurry? Y/N

Have you ever had eye therapy/patching? _____

Have you had any eye surgeries? _____

Have you had any eye injuries? _____

Do you have eyeglasses? Y/N Contact lenses? Y/N Type? _____

Any other problems that you would like to discuss with the doctor? _____