Patient Registration and Health History

Date: _____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Female ☐ Male

First Name: _____ Last Name: _____ Age: _____ Birth Date: _____

Parent's Name (If patient is child): _____ If a student, Grade: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact Phone: _____ E-mail Address: _____

Occupation: _____ Is this your first visit to our office? ☐ Yes ☐ No

What is the reason for seeking vision care at this time? _____

_____

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent Insured's Date of Birth: _____

Insured's Name: _____ Insured's Employer: _____

Insured's ID: _____ Insurance Plan Name: _____ Auth. No.: _____

☐ Please check this box if there have been no changes to your medical and ocular history since your last visit.

Patient's Visual Symptoms
(Check each you have had)

- ☐ None, routine eye exam
- ☐ Blurred distance vision
- ☐ Blurred near vision
- ☐ Burning eyes
- ☐ Discomfort at NEAR tasks (e.g., reading, sewing)
- ☐ Double vision
- ☐ Dry eyes
- ☐ Eye strain
- ☐ Headaches related to eyes
- ☐ Itching eyes
- ☐ Light sensitivity
- ☐ Red eyes
- ☐ See flashing lights
- ☐ See floaters or spots
- ☐ Temporary loss of vision
- ☐ Twitching eyelids
- ☐ Variable vision
- ☐ Watery eyes
- ☐ Other

Patient's Health History
(Check each you have had)

- ☐ None
- ☐ Allergies
- ☐ Asthma
- ☐ Blackouts
- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Cholesterol
- ☐ Diabetes
- ☐ Drug sensitivity
- ☐ Glaucoma
- ☐ Hay fever
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Lazy eye (Amblyopia)
- ☐ Migraine headaches
- ☐ Macular Degeneration
- ☐ Poor color vision
- ☐ Skin conditions
- ☐ Thyroid condition
- ☐ Tuberculosis
- ☐ Turned eye
- ☐ Other

Family Health History
(Check each if someone in your family has had)

- ☐ None
- ☐ Allergies
- ☐ Asthma
- ☐ Blackouts
- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Diabetes
- ☐ Drug sensitivity
- ☐ Glaucoma
- ☐ Hay fever
- ☐ Heart condition
- ☐ High blood pressure
- ☐ Lazy eye (Amblyopia)
- ☐ Migraine headaches
- ☐ Macular Degeneration
- ☐ Poor color vision
- ☐ Skin conditions
- ☐ Thyroid condition
- ☐ Tuberculosis
- ☐ Turned eye
- ☐ Other

Do you consider your health: ☐ Good ☐ Fair ☐ Poor

When was your last visit to your medical physician? _____ What is your medical physician's name? _____

Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Do you smoke, consume alcohol, or use recreational drugs? ☐ Yes ☐ No If yes, please explain: _____

Are you presently taking any medication or drugs? ☐ Yes ☐ No

If yes, what drugs are you taking? _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, which? _____

Have you had any serious eye disease, eye injury, or eye surgery? ☐ Yes ☐ No

If yes, please explain: _____

When was your last eye exam? _____ What is your previous eye doctor's name? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, which type? ☐ Hard ☐ Soft ☐ Disposable

Signature: _____ Date: _____

Voluntary Language Survey

1.) What is your preferred spoken language?
☐English ☐Spanish ☐Chinese ☐Korean ☐Tagalog ☐Vietnamese ☐Other _____

2.) What is your preferred written language?
☐English ☐Spanish ☐Chinese ☐Korean ☐Tagalog ☐Vietnamese ☐Other _____

3.) What is your race?
☐White ☐American Indian / Alaskan Native ☐Asian ☐Black / African American ☐Native Hawaiian / Pacific Islander ☐Other _____

4.) What is your ethnicity? ☐Of Hispanic or Latino origin ☐Non Hispanic or Latino origin

☐ I decline to participate in this survey.