Patient Registration

Please complete the following information.

Patient Information

Patient Name (First, Middle, Last)	Suffix (Jr.,Sr.)	Salutation (Mr.,Ms.)	Nickname	Birth State	Sex	Age	Date of Birth	Today's Date

Address	Address Type (Home, Billing Address, Office/Business)

Home Phone	Cell Phone	Email Address	Preferred Communication (Cell, Email)

Spouse's Name	Spouse's Phone #

Employer	Pharmacy

Responsible Party Information

Responsible Party's Name (Salutation, First, Middle, Last)	Date of Birth	Patient's Relationship to the Responsible Party (Self, Spouse, Child)		
		Home Phone	Cell Phone	Work Phone / Ext

Address (Street, City, State, ZIP)	Email Address	Gender

Primary Insurance

Insured's Name	Date of Birth	ID Number

Insurance Company Name	Insurance Co. Phone

Secondary Insurance

Insured's Name	Date of Birth	ID Number

Insurance Company Name	Insurance Co. Phone

Contacts

Name/ Relationship/ Address	Title/ Specialty	Emergency Contact	Release of Medical Information	Phone

Physicians

Specialty	Physician's Name	Phone	Address	
Primary Care Physician				
Referring Physcian				
Optometrist				

Date _____ Signature _____

MID-STATE EYE

PATIENT'S MEDICAL HISTORY QUESTIONNAIRE - Page 1

Date _____ Name: _____

What is the main reason for today's exam? _____

CURRENT EYE HISTORY:

Do you have any of the following symptoms? (with your current glasses or contact lenses)

Please Check Response	YES	NO	Please Check Response	YES	NO
Headaches	_____	_____	Drooping Eyelid	_____	_____
Glare/Light Sensitivity	_____	_____	Redness	_____	_____
Tired Eyes	_____	_____	Sandy/Gritty Feeling	_____	_____
Amblyopia (Lazy Eye)	_____	_____	Crossed Eyes	_____	_____
Burning	_____	_____	Blurred Vision at Distance	_____	_____
Dryness	_____	_____	Blurred Vision at near	_____	_____
Excess Tearing/Watering	_____	_____	Distored Vision (halos)	_____	_____
Eye Pain or Soreness	_____	_____	Double Vision	_____	_____
Foreign Body Sensation	_____	_____	Floaters or Spots	_____	_____
Infection of Eye or Lid	_____	_____	Fluctuating Vision	_____	_____
Itching	_____	_____	Loss of Vision	_____	_____
Keratoconus	_____	_____	Loss of Side Vision	_____	_____
Mucous Discharge	_____	_____			

Do you currently wear glasses ? _____YES _____NO

Do you currently wear contact lenses ? _____YES _____NO

Are you interested in LASIK? _____YES _____NO

At what age did you start wearing glasses?_____ / Contacts? _____

When was your last eye exam? _____

When did you last update your glasses prescription? _____

Past Eye Problems or Injuries: _____

Past Eye Surgeries: _____

Current Medications: _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

SOCIAL HISTORY:

Do you use nutritional supplements (vitamins, etc.)? _____YES _____NO

Do you engage in regular exercise? _____YES _____NO

Do you drink alcohol? _____YES _____NO If yes, how much: _____

Do you smoke? _____YES _____NO If yes, how much: _____

Have you ever smoked? _____YES _____NO When did you stop smoking? _____

What are your hobbies / Interests: _____

PATIENT'S MEDICAL HISTORY QUESTIONNAIRE - Page 2

Date _____ Name:

Review of Systems: Please check any condition for which you are currently being treated.

Constitutional Symptoms:
____Fever
____Fatigue
____Other_____

Ear, Nose, Throat, Mouth:
____Hearing Loss
____Sinus Disorders
____Other

Cardiovascular:
____Atrial Fibrillation
____Heart Disease
____Hypertension
____Stroke/TIA
____Other_____

Respiratory:
____Asthma
____Emphysema/COPD
____Shortness of Breath
____Other_____

Gastrointestinal:
____Intestinal Conditions
____Other_____

Urinary:
____Flomax Use
____Kidney Disease
____Urinary Conditions/Symptoms
____Other_____

Musculoskeletal:
____Arthritis
____Muscle/Joint/Back Pain
____Other

Skin:
____Herpes
____Rash/Itching
____Rosacea
____Shingles
____Skin Cancer
____Other_____

Neurological:
____Multiple Sclerosis
____Frequent Headaches
____Convulsions/Seizure
____Other_____

Psychiatric:
____Memory Loss
____Depression
____Other_____

Endocrine:
____Diabetes
____Thyroid Disease
____Other

Blood:
____Anemia
____Cholesterol
____Other

Allergic/Immunologic:
____Seasonal Allergies
____Lupus
____Other

Other:
____Pregnant
____Nursing
____Other Conditions
_____
_____

IMMEDIATE FAMILY HISTORY:
Check if your Grandparents, Parents or Siblings had any of the following conditions.

Eye Diseases	Relationship	Systemic Diseases	Relationship
_____Amblyopia (Lazy Eye)	_____	_____Arthritis	_____
_____Blindness	_____	_____Cancer	_____
_____Cataract(s)	_____	_____Diabetes	_____
_____Color Blindness	_____	_____Heart Disease	_____
_____Eye Tumors	_____	_____High Blood Pressure	_____
_____Glaucoma	_____	_____Kidney Disease	_____
_____Glaucoma Suspect	_____	_____Lupus	_____
_____Macular Degeneration	_____	_____Stroke	_____
_____Retinal Detachment	_____	_____Thyroid Disease	_____
_____Strabismus (eye Turn)	_____	_____Other Diseases	_____
_____Keratoconus	_____		
_____Other Eye conditions	_____		