Member
American Optometric Association

CONFIDENTIAL PATIENT REGISTRATION FORM

(large font version)

PERSONAL INFORMATION				
Last Name:	**First Name:**			**MI:**
Mailing Address:	**Town:**	**State:**	**Zip Code**	
Home Address *(if different)*:	**Town:**	**State:**	**Zip Code**	
Best phone # to reach you:	**Cell Phone #:**	**Daytime Phone#**		
Social Security #: - -	**Date of Birth:** / /	**Gender:**	**Occupation:**	**Employer:**
Emergency Contact Name:	**Emergency Contact Phone #:**	**Relation to patient:**		
Date of Last Eye Exam: / /	**Were Your Pupils Dilated?** *Yes / No*	**Today's Date:** / /		

MEDICAL INFORMATION

What is your general health?

Do you have problems with any of the follow systems? *Check 'yes' or 'no'*

	YES	NO		YES	NO		YES	NO		YES	NO
Eyes	☐	☐	Respiratory	☐	☐	Cardiovascular	☐	☐	Ears/Nose/Throat	☐	☐
Mental	☐	☐	Blood/Lymph	☐	☐	Musculoskeletal	☐	☐	Endocrine (glands)	☐	☐
Nervous	☐	☐	Genitourinary	☐	☐	Gastrointestinal	☐	☐	Integumentary (skin)	☐	☐

If you checked 'YES' above, please explain:

Are you diabetic, pre- or borderline? *Yes / No*
If 'yes', when were you diagnosed?

Do you have allergies? *Yes / No*
If 'yes', to what are you allergic?

If female, are you pregnant? *Yes / No*
If 'yes', how many months?

Do you take any medications? *Yes / No*
If 'yes', please list:

Are you allergic to any medicines? *Yes / No*
If 'yes', which ones?

Have you had any operations? *Yes / No*
If 'yes', what kind & when?

Do you have any other health problems? *Yes / No* If 'yes', please list:

Do you smoke? *Yes / No*	**Do you drink alcohol?** *Yes / No*	**Do you use recreational drugs?** *Yes / No*

Name of family doctor:	**Family doctor's address & phone:**	**Date of last visit:** / /

FAMILY HISTORY

Does anyone in your family have the following? : *Check 'yes' or 'no'*

	YES	NO	*(RELATIONSHIP):*		YES	NO	***(RELATIONSHIP):***
Diabetes	☐	☐	_____	High blood pressure	☐	☐	_____
Cataracts	☐	☐	_____	Retinal detachment	☐	☐	_____
Glaucoma	☐	☐	_____	Macular degeneration	☐	☐	_____

Other eye conditions?_____

PERSONAL EYE INFORMATION

Do you wear glasses for distance? *Yes / No*		**Do you wear glasses for reading?** *Yes / No*	
Do you wear contact lenses? *Yes / No*		**What brand contacts?**	
Have you had eye operations or injuries? *Yes /No*		**What kind & when?**	
Do you have glaucoma? *Yes / No*	**Cataracts?** *Yes /No*	**Dry eyes?** *Yes / No*	**Blurred vision?** *Yes / No*

Any additional information? _____

How did you hear about us?_____ _____

Doctor's initials: _____