CONFIDENTIAL PATIENT REGISTRATION FORM

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 #:**	**e-mail address** (for office use only)
Social Security #: - -	**Date of Birth:** / /	**Gender:**	**Occupation:** / **Employer:**
Emergency Contact Name:	**Emergency Contact Phone #:**	**Relation to patient:**	
Date of Last Eye Exam: *approximately*	**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)	☐	☐

Are you diabetic, pre- or borderline? *Yes / No* If 'yes', when were you diagnosed?	**If female, are you pregnant?** *Yes / No* If 'yes', how many months?

Do you take any medications? *(including over-the-counter)* *Yes / No*
If 'yes', please list:

Are you allergic to any medicines or have allergies? *Yes / No*

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:** *approximately* / /

FAMILY HISTORY

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

	YES	NO	RELATIONSHIP TO YOU:		YES	NO	RELATIONSHIP TO YOU:
Diabetes	☐	☐	_____	Glaucoma	☐	☐	_____
High blood pressure	☐	☐	_____	Cataracts	☐	☐	_____
Retinal detachment	☐	☐	_____	Other eye conditions?			_____
Macular degeneration	☐	☐	_____	_____			

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*		**If yes, what brand of contacts?**	
Have you had eye operations or injuries? *Yes /No*		**What kind of injury/operation?**	
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 signature: _____