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2541 Sand Pike Boulevard
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PATIENT REGISTRATION (PLEASE PRINT)

Full Name:_____Date of Birth: _____

Preferred Name:_____ Sex(circle): M / F SSN: _____

Race/Ethnicity(circle): Caucasian, African American, Asian, Hispanic/Latino, Native American, Pacific Islander, Other

Address:_____City:_____State:_____Zip:_____

Home#:_____Cell#:_____

Work#:_____E-mail:_____

Marital Status: ___Married ___Single ___Widowed ___Other:_____

Occupation:_____Employer:_____

How did you hear about us? ___Friends/Family Name of Person if referred: _____
___Office Sign ___Insurance Company ___Internet Search ___Other: _____

When was your last eye exam? _____When was your last physical? _____
Currently wear: ___Glasses ___Contact Lenses
Interested in: ___Glasses ___Contact Lenses ___LASIK

PLEASE PROVIDE THE FRONT DESK WITH YOUR DRIVER LICENSE AND YOUR CURRENT INSURANCE CARD(S) (MEDICAL AND VISION INSURANCE)

I authorize that my exam and medical information may be shared with the following people family members and friends: (list up to two - if patient is a minor, health information will be shared with both parents unless otherwise stated)

Name:_____Relationship:_____
Phone Number:_____

Name:_____Relationship:_____
Phone Number:_____

I authorize that my exam and medical information may be shared with the following physician/doctor offices:

Primary Care Physician/Office:_____
Specialist Physician/Office:_____

Signature _____Date _____

Many medical conditions and medications affect the eyes. Please fill out your medical history as completely as possible.

Patient Medical Information

Please circle and list all conditions that apply

Cardiovascular **Y / N**
High Blood Pressure | Heart Failure
Other_____
Medications_____

Hematologic **Y / N**
High Cholesterol | Anemia
Other_____
Medications_____

Endocrine **Y / N**
Diabetes | Thyroid Disorder
Other_____
Medications_____

Allergic/Immunologic **Y / N**
Hay Fever | Sjogren's Syndrome
Rheumatoid Arthritis | Lupus
Other_____
Medications_____

Gastrointestinal **Y / N**
Crohn's | Ulcerative Colitis
Other_____
Medications_____

Genitourinary **Y / N**
Kidney Disease | Bladder Disease
Prostate Disease | STIs/STDs
Other_____
Medications_____

Neurologic **Y / N**
Migraine Headaches | Multiple Sclerosis
Myasthenia Gravis | Stroke
Other_____
Medications_____

Psychiatric **Y / N**
Anxiety | Depression | ADHD
Other_____
Medications_____

Respiratory **Y / N**
Asthma | Emphysema | COPD | Sleep Apnea
Other_____
Medications_____

Skin **Y / N**
Eczema | Psoriasis | Rosacea
Other_____
Medications_____

Musculoskeletal **Y / N**
Osteoporosis | Osteoarthritis
Ankylosing Spondylitis
Other_____
Medications_____

Cancer: Type_____ **Y / N**

Additional Medical Information

Additional Medical Conditions _____

_____

Additional Medications _____

_____

Vitamins/Supplements _____

_____

Medication Allergies _____

_____

Pregnant or Nursing **Y / N**

Tobacco Use
Current | Former | Never
Smoking | Smokeless | Vaping
Frequency _____

Alcohol Use
Current | Former | Never
Frequency _____

Other Drug Use _____

Primary Care Physician _____
Pharmacy _____

Ocular History

Please circle and list all conditions that apply

Cataracts | Glaucoma | Macular Deg.
Dry Eyes | Strabismus | Keratoconus
Eye Injury _____
Eye Surgery _____
Eye Drops _____
Eye Vitamins _____
Other _____

Family History

Please circle
Father, Mother, Brother, Sister, Grandparents

Glaucoma	F	M	B	S	GP	None
Cataracts	F	M	B	S	GP	None
Macular Deg.	F	M	B	S	GP	None
Blindness	F	M	B	S	GP	None
Diabetes	F	M	B	S	GP	None
High Cholesterol	F	M	B	S	GP	None
High Blood Pressure	F	M	B	S	GP	None

Additional Notes_____

_____