PATIENT REGISTRATION

PLEASE PRINT ALL INFORMATION

NAME:______________________ DOB:____________ SSN:______________________

STREET ADDRESS:______________________ CITY:____________ STATE:______________

PRIMARY PHONE#______________________ SECONDARY PHONE#______________________

SEX: ❑MALE ❑FEMALE LANGUAGE: ❑ENGLISH ❑SPANISH ❑OTHER:_____________________ ETHNICITY: ❑HISPANIC ❑NOT HISPANIC

MARITAL STATUS: ❑SINGLE ❑MARRIED ❑OTHER RACE: ❑BLACK/AFRICAN AMERICAN ❑WHITE ❑OTHER:______________________

EMPLOYMENT STATUS: ❑STUDENT ❑FULLTIME ❑PARTTIME ❑RETIRED ❑NOT EMPLOYED ❑ACTIVE MILITARY ❑DISABLED

EMPLOYER/SCHOOL:______________ POSITION:____________ ADDRESS:______________________

REFERRED BY:____

RESPONSIBLE PARTY'S NAME (IF UNDER 18)______________________ DOB:______________________

SSN:______________________ EMAIL ADDRESS:______________________

EMERGENCY CONTACT/RELATIONSHIP:______________________ TELEPHONE #:______________________

RELEASE OF INFORMATION

HIPPA RELEASE FORM- BY SIGNING BELOW I AUTHORIZE THE RELEASE OF INFORMATION INCLUDING THE DIAGNOSIS, RECORDS; EXAMINATION RENDERED TO ME AND CLAIMS INFORMATION. THIS INFORMATION MAY BE RELEASED TO:

[ ] SPOUSE: ____

[ ] CHILD AND/OR CHILDREN: ____

[ ] OTHER: ____

[ ] INFORMATION IS NOT TO BE RELEASED TO ANYONE.

THIS *RELEASE OF INFORMATION* WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.

MESSAGES

PLEASE CALL MY: [ ] HOME [ ]WORK [ ]CELLPHONE

NUMBER:____

IF UNABLE TO REACH ME YOU MAY LEAVE A MESSAGE

[ ] DETAILED- YES OR NO

[ ] GENERALIZED INFORMATION AND/OR TO RETURN YOUR CALL

SIGNED:______________________________________ DATE:______________________

WITNESS: ______________________________________ DATE:______________________

Medical History Questionnaire

Name: ____ DOB: ___/___/___ Date ___/___/___

Medical History:

Do you have any allergies to medications? ❑ No ❑ Yes If yes, explain ______________________
____

List any medications you are taking (including oral contraceptives, aspirin, over the counter medications and home remedies): ____
____
____

Circle any of the following that you have had: Hysterectomy, Gallbladder, Vertebra, Vasectomy, Appendectomy, Tonsillectomy, T & A (tonsils and adenoids), Cataract Surgery, Lasik, Sleep Apnea, Stents, List any others:____

Circle any of the following that you have had: Crossed Eyes, Lazy Eye, Dropping Eyelid, Prominent Eyes, Glaucoma, Retinal Disease, Cataracts, Eye Infections, or Eye Injury.

Are you pregnant and or nursing? ❑ No ❑ Yes
Do you wear glasses? ❑ No ❑ Yes
Do you wear contact lenses? ❑ No ❑ Yes
Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other
Do you drive? ❑ No ❑ Yes If yes, do you have visual difficulty when driving? ❑ No ❑ Yes

Family History:

Please note any family history (parents, grandparents, sibling and/or children, living or deceased for the following medical conditions:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❑	❑	❑	______________________
Cataract	❑	❑	❑	______________________
Crossed / Lazy Eye	❑	❑	❑	______________________
Glaucoma	❑	❑	❑	______________________
Macula Degeneration	❑	❑	❑	______________________
Retinal Detachment / Disease	❑	❑	❑	______________________
Arthritis	❑	❑	❑	______________________
Cancer	❑	❑	❑	______________________
Diabetes	❑	❑	❑	______________________
Heart Disease	❑	❑	❑	______________________
High Blood Pressure	❑	❑	❑	______________________
Kidney Disease	❑	❑	❑	______________________
Lupus	❑	❑	❑	______________________
Thyroid Disease	❑	❑	❑	______________________
Other	______________________			

Social History:

Do you use tobacco products? ❑ No ❑ Yes _______packs per day
Do you drink alcohol? ❑ No ❑ Yes
Do you work at a computer/VDT? ❑ No ❑ Yes
Do you use addictive agents? ❑ No ❑ Yes
Have you been exposed to or infected with: ❑ Gonorrhea ❑ Syphilis ❑ HIV ❑ Hepatitis ❑ None

Your Medical History:

Review Of Systems: Please indicate if any of the following medical conditions pertain to you. **All fields must be marked.**

Integumentary:	**No**	**Yes**	**?**
Eczema	❑	❑	❑
Rosacea	❑	❑	❑
Psoriasis	❑	❑	❑
Other	❑	❑	❑

Neurologic:	**No**	**Yes**	**?**
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
Multiple Sclerosis	❑	❑	❑
Epilepsy	❑	❑	❑

Eyes:	**No**	**Yes**	**?**
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Redness	❑	❑	❑
Sandy or Gritty	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body	❑	❑	❑
Excess Tearing	❑	❑	❑
Light Sensitivity	❑	❑	❑
Eye Pain	❑	❑	❑
Chronic Infection	❑	❑	❑
Sties or Chalazion	❑	❑	❑
Flashes/Floaters	❑	❑	❑
Tired Eyes	❑	❑	❑

Ears, Nose, Mouth, Throat:	**No**	**Yes**	**?**
Allergies	❑	❑	❑
Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat/Mouth	❑	❑	❑

Genitourinary:	**No**	**Yes**	**?**
Genitals	❑	❑	❑
Bladder	❑	❑	❑
Kidney	❑	❑	❑
STD	❑	❑	❑

Psychiatric:	**No**	**Yes**	**?**
Depression	❑	❑	❑
Panic Disorder	❑	❑	❑
Schizophrenia	❑	❑	❑
Nerves	❑	❑	❑
Other	❑	❑	❑

Gastrointestinal:	**No**	**Yes**	**?**
Crohn's	❑	❑	❑
Colitis	❑	❑	❑
Ulcer	❑	❑	❑
Digestive	❑	❑	❑
Acid Reflux	❑	❑	❑
Irritable Bowel	❑	❑	❑
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
Other	❑	❑	❑

Vascular:	**No**	**Yes**	**?**
Heart Disease	❑	❑	❑
Stoke	❑	❑	❑
High Blood Pressure	❑	❑	❑
Cholesterol	❑	❑	❑
Heart Pain	❑	❑	❑
Other	❑	❑	❑

Lymphatic/Hematologic:

	No	**Yes**	**?**
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
Leukemia	❑	❑	❑
Blood Thinner	❑	❑	❑
Large Blood Loss	❑	❑	❑
Other	❑	❑	❑

Muskuloskeletal:	**No**	**Yes**	**?**
Fibromyalgia	❑	❑	❑
Muscular Dystrophy	❑	❑	❑
Osteoarthritis	❑	❑	❑
Ankylosing Spondylitis	❑	❑	❑
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
Lupus	❑	❑	❑

Respiratory:	**No**	**Yes**	**?**
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Respiratory Infection	❑	❑	❑

Endocrine:	**No**	**Yes**	**?**
Diabetes	❑	❑	❑
Thyroid Dysfunction	❑	❑	❑
Hormonal Dysfunction	❑	❑	❑

Constitutional:	**No**	**Yes**	**?**
Disability	❑	❑	❑
Weight Loss/Gain	❑	❑	❑
Fever	❑	❑	❑
Fatigue	❑	❑	❑
Trauma	❑	❑	❑

(OFFICE USE ONLY)

P, F, S Hx Prob Pertient (1area) ______
Complete (2-3 areas) ______
ROS Prob Pertient (1 sys) ______
Ext. (2-9) ______
Complete (>10) ______

- ☐ Primary ROS taken today
- ☐ Reviewed ___/__/___ ROS & PFSH today
- ☐ Reviewed ___/__/___ ROS & PFSH today
- ☐ Reviewed ___/__/___ ROS & PFSH today
- ☐ Reviewed ___/__/___ ROS & PFSH today
- ☐ Reviewed ___/__/___ ROS & PFSH today

Changes Noted:

Initials: _________ Date: ___________
_________ Date: ___________
_________ Date: ___________
_________ Date: ___________
_________ Date: ___________

SIGNATURE

X____ Date ________________
X____ Date ________________
X____ Date ________________
X____ Date ________________
X____ Date ________________

CASE HISTORY: Prob-focused _____________ Exp. Prob-focused _______________ Detailed __________ Comprehensive __________