**PATIENT REGISTRATION FORM**

**NAME: _____ LAST EYE EXAM: _____**

**DATE OF BIRTH: _____ COMPUTER USE (Hrs/day):_____**

**OCCUPATION: _____ HOBBIES: _____**

1. **What is your reason for today's eye exam? (Please mark all that apply)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Routine eye exam | | Dry eyes | | Lazy eye | | Headaches | |
| Blur at distance | | Burning/ Itching | | Red eye | | Broken glasses | |
| Blur at near | | Flashes | | Floaters/Spots | | Contact Lenses | |
| Double vision | | Eye pain/Discomfort | | Glaucoma | | Other | |

2. **Medical History (Please mark all that apply)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Diabetes (High blood sugar) | | Arthritis/Joint pain | | Skin condition | | Thyroid | |
| High blood pressure | | Asthma | | Breathing problems | | Cancer | |
| High cholesterol | | Depression/Anxiety | | Stomach problems | | Allergies | |
| Heart problems | | Stroke | | Heart attack | | Other | |

3. **Ocular (Eye) History (Please mark all that apply)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Glaucoma | | Cataracts | | Retinal Conditions | | Lazy eye(Amblyopia) | |
| Macular Degeneration | | Flashes | | Floaters/ Spots | | Eye injury | |
| Eye surgery | | Metal/Foreign body | | Other | | | |

4. **Do you take any medications? YES/NO (If YES, please list)**

   _____
   _____
   _____

5. **Do you have any allergies? YES/NO (If YES, please list)**

   _____

6. **Do you smoke? YES/NO (If YES, how often?) _____**

7. **Are you pregnant? YES _____ NO_____ N/A_____**

8. **Please mention the MEMBERS IN YOUR FAMILY who have the following conditions:**

Diabetes _____ High Blood Pressure_____ Cancer_____
Heart problems _____ Thyroid _____ High Cholesterol _____

Macular Degeneration _____Cataracts _____ Glaucoma_____
Retinal Disease_____ Blindness_____ Lazy/Crossed eye (Amblyopia) _____
Other_____

9. **Do you use any eye drops? YES/ NO (If YES, please list) _____**

10. **Glasses/Contact Lenses**
    - Do you currently wear any prescription glasses? YES/NO (if YES, how old are they?) _____
    - Do you like your current glasses? YES/NO (If NO, Why?) _____
    - Do you currently wear contact lenses? If YES, what brand and how often? _____
    - Do you like your current brand of contact lenses? (If NO, Why?) _____
    - How old is your current contact lens prescription? _____

11. **Please take a moment to give us your thoughts on extended clinic hours (Please CHECK the box/comment)**
    - prefer regular weekday appointments **(9.00am -5.30pm)** _____
    - I I prefer weekday evening appointments **(5.30pm – 7.00pm)** _____
    - I prefer weekend appointments **(Saturdays) _____**
    - WHO SHOULD WE THANK, FOR REFERRING YOU TO OUR CLINIC TODAY? _____