EYE See OPTOMETRY

NEW PATIENT REGISTRATION

In order to provide you the best possible care, please complete this form. All information is strictly CONFIDENTIAL.

PATIENT INFORMATION

First Name ____________ Home Phone ____________ Occupation ____________

Last Name ____________ Work Phone ____________ Safety Glasses? Y / N Computer? Y / N

Email ____________ Cell Phone ____________ Driver's Licence? Y / N Lic. Class ____________

☐ I give consent to receive news, events, or promotional details via email and/or text messaging.

VISION HISTORY

Main reason for visit today? ____________

CURRENT SYMPTOMS

☐ Burning	☐ Redness	☐ Dryness	☐ Mucous	☐ Enlarged pupil
☐ Itching	☐ Tearing	☐ Pain	☐ Blurred vision	☐ Double vision

Do you wear glasses?	Y / N	**Type:**	Distance	Readers	Bifocal	Trifocal	Progressive	
Do you wear contacts?	Y / N	**Type:**	Daily	Bi-weekly	Monthly	Yearly	RGP/Hard	Custom

EYE CONDITIONS?

	☐ Cataract	☐ Retinal Detachment	☐ Eye Infection	☐ Blepharitis
☐ Amblyopia ("lazy eye")	☐ Keratoconus	☐ Macular Degeneration	☐ Eye Injury	☐ Dry Eyes
☐ Strabismus ("eye turn")	☐ Glaucoma	☐ Diabetic Eye Disease	☐ Eye Surgery	☐ Uveitis/Iritis

MEDICAL HISTORY

☐ Cancer	☐ Heart	☐ Asthma	☐ Multiple Sclerosis
☐ Cholesterol	☐ Stroke	☐ COPD	☐ Sarcoidosis
☐ Diabetes	☐ Arthritis	☐ Thyroid	☐ Anemia
☐ Hypertension	☐ HIV/AIDS	☐ Lupus	☐ Hepatitis

ALLERGIES

DOCTOR: ____________ Doctor Phone: ____________ Doctor Fax: ____________

MEDICATIONS

SOCIAL HISTORY

☐ Smokes Packs/day: ____________ ☐ Cell phone # hours: ______

☐ Alcohol Amount: ☐ Tablet use # hours:

HOBBIES

FAMILY HISTORY

☐ Blindness	☐ Crossed/Lazy Eye	☐ Macular Degeneration	☐ Cancer	☐ Heart
☐ Cataract	☐ Glaucoma	☐ Retinal Detachment	☐ Diabetes	☐ Stroke

ACKNOWLEDGEMENT OF ABOVE INFORMATION

☐ I certify that the information provided on this form is accurate and I wish to continue my care under said terms.

____________ Signature

____________ Date