Advanced Eyecare Patient Registration Form

Patient Information – Please Print Clearly

Last: ________________________ First: _______________________ Middle Initial ____ Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Address: ____ Apt #: ___________________

City, State, Zip: ____ Date of Birth: ____/____/____

Cell phone: _______________________ Home Phone _____________________Work Phone______________________

Marital Status: _____________ Occupation: ___________________________________ Gender: ☐ F ☐ M ☐ Other

Email: ____ Last Eye Exam: ____/____/____

Insurance Information

	Insurance Company	Subscriber Name	Relation	Subscriber #	Subscriber Birthdate
Vision	_________________	_________________	__________	_________________	____/____/____
Primary	_________________	_________________	__________	_________________	____/____/____
Secondary	_________________	_________________	__________	_________________	____/____/____
Other	_________________	_________________	__________	_________________	____/____/____

Medical History Questionnaire

Do you have any allergies to medication? No Yes If yes, please list _________________________________

____

List medications you take (including eye drops, aspirin, and over-the-counter medications) and REASON:

____

____

____

List all major injuries, surgeries, and/or hospitalizations you have had: _________________________________

____

List any of the following that you have had – eye surgery, laser, or injury: _______________________________

Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _______________

Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? _______________

Type of contact lenses: Rigid Soft Brand if known_______________________________________

Are you pregnant and/or nursing? No Yes

Social History

Do you use tobacco products? No Yes If yes, type / amount / how long? ________________________________

Do you drink alcohol? No Yes If yes, type / amount / how long? ________________________________

Do you use drugs? No Yes If yes, type / amount / how long? ________________________________

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Yes	Relationship
Blindness			________________
Cataract			________________
Glaucoma			________________
Lazy Eye/Muscle Imbalance			________________
Macular Degeneration			________________
Retinal Detachment/Disease			________________
Cancer			________________
Diabetes			________________
Heart Disease			________________
High Blood Pressure			________________
Other			________________

Review of Systems

Do you currently, or have you ever had, any problems in the following area:

No Yes No Yes

Constitutional
Fever
Weight Loss/Gain
Eyes
Loss of Vision
Blurred Vision
Double Vision
Dryness
Eye Discharge
Redness
Sandy or Gritty Feeling
Itching
Burning
Foreign Body Sensation
Tearing or Watering
Glare/Light Sensitivity
Crossed/Lazy Eye
Droopy Eyelid(s)
Neurological
Headaches
Migraines
Gout

Integumentary
Skin
Rosacea
Eczema/Psoriasis
Ear, Nose, Mouth, Throat
Sinusitis
Loss of Hearing/Smell
Vertigo
Dry Mouth/Throat
Chronic Cough
Respiratory
Asthma
Emphysema
Vascular/Cardiovascular
Diabetes
High Blood Pressure
Heart/Circulation Problems
Bones/Joints/Muscles
Arthritis
Rheumatoid Arthritis
Muscle Pain/Weakness
STD

Lymphatic/Hematologic
Anemia
Blood Disorders
Allergic/Immunologic
Allergies/Hay Fever
Lupus
Psychiatric
Anxiety
Depression
Endocrine
Hypothyroid
Hyperthyroid
Gastrointestinal
Ulcers
Colitis
Chronic Diarrhea
Liver Disease
Hepatitis
Genitourinary
Kidney/bladder
Prostate

Seizures

If you answered yes to any of the above, or have a condition not listed, please explain and list medications: