EYEPEOPLE PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name	Birthdate	Age	☐ M ☐ F	Date
Street Address	City		State	Zip
Home/Cell Phone	Work Phone	Email		
Occupation	Employer		☐ New Patient ☐ Previous	

VISION INSURANCE

Insurance	Primary Member's Name	Primary Member's Birthdate
Primary Member's ID	Relationship to Primary Member ☐ Self ☐ Spouse ☐ Dependent	Last Four of Primary's SSN

REASON FOR TODAY'S VISIT

- ☐ Routine/Glasses Exam
- ☐ Contact Lens Exam
- ☐ LASIK Evaluation
- ☐ Retinal Evaluation/Imaging
- ☐ Dry Eye Evaluation
- ☐ Glaucoma Evaluation
- ☐ Specialty Contact Lens Fit (i.e. scleral lenses)
- ☐ Other _____

PATIENT MEDICAL HISTORY

Date of your last eye exam? _____ Do you wear glasses? ☐ N / ☐ Y Type (circle)? Dist / Near / Comp / Prog / BF

Check all that apply: ☐ Blurry vision (circle): Distance / Reading / Computer ☐ Double vision ☐ Flashes/floaters ☐ Dry eyes ☐ Itchy eyes ☐ Lost/broke glasses ☐ Out of contacts

Do you or a family member have problems with any of the following (check all that apply)?

	SELF	FAMILY	SPECIFY
Amblyopia (lazy eye)	☐	☐	_____
Strabismus (eye turn)	☐	☐	_____
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____

	SELF	FAMILY	SPECIFY
Diabetes	☐	☐	_____
High Blood Pressure	☐	☐	_____
High Cholesterol	☐	☐	_____
Cardiovascular Disease	☐	☐	_____
Autoimmune Disease	☐	☐	_____
Cancer	☐	☐	_____

Any eye surgery or trauma? ☐ N / ☐ Y

Explain: _____

Are you pregnant or nursing? ☐ N / ☐ Y

Other Conditions: _____

Cigarettes/tobacco? Former ☐ Daily

Alcohol? Occasional Social ☐ Other

CURRENT MEDICATIONS:

DRUG ALLERGIES

☐ Penicillin ☐ Sulfa ☐ Other _____

DRY EYE QUESTIONNAIRE

Do you experience any of the following symptoms: ☐ Burning ☐ Teary/watery ☐ Stinging ☐ Redness ☐ Blurred vision ☐ Scratchiness ☐ Grittiness ☐ Irritation

CONTACT LENS HISTORY

What type of contact lenses do you wear (if applicable)? ☐ Soft ☐ Hard

Contact Lens Brand (if known): _____

How often do you replace your lenses? ☐ Daily ☐ 2wks ☐ Monthly

How many times a week do you wear your lenses? _____

Do you sleep in your lenses? ☐ N / ☐ Y ☐ First Time Contacts

COMPUTER USE HISTORY

Hours on the computer per day? _____

Do you experience any of the following while using the computer:

- ☐ Eye strain
- ☐ Blurred vision
- ☐ Light sensitivity
- ☐ Eye fatigue
- ☐ Headaches
- ☐ Glare