**INITIAL PATIENT HISTORY & REGISTRATION**

DATE _____ REFERRED BY _____

□ MR. □ MS. PLEASE PRINT FULL NAME

□ MRS. □ DR.

PATIENT'S NAME _____ AGE _____ SEX _____ BIRTHDATE _____

FIRST MIDDLE LAST

ADDRESS _____ PHONE (H) _____

STREET CITY STATE ZIP

EMPLOYER _____ OCCUPATION _____ PHONE (W) _____

SOC. SEC. NO. _____ PRIMARY CARE PHYSICIAN _____

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***Please answer the following questions about your medical history:***

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)? □ YES □ NO
   If YES, please explain: _____
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)? □ YES □ NO
   If YES, please explain: _____
3. Have you ever had any surgery? □ YES □ NO If YES, please explain: _____
   _____
4. Do you take any medications? □ YES □ NO If YES, please explain: _____
   _____
5. Do you have any drug allergies? □ YES □ NO If YES, please explain: _____
6. Have you had any of the following problems?

| | YES | NO | If YES, please explain: |
|---|---|---|---|
| Chronic fever, unexpected weight loss/gain, fatigue | □ | □ | _____ |
| Ear/nose/throat problems (e.g., hearing loss, sinus problems) | □ | □ | _____ |
| Heart problems (e.g., chest pain, irregular heartbeat) | □ | □ | _____ |
| Respiratory problems (e.g., shortness of breath, wheezing, asthma, bronchitis) | □ | □ | _____ |
| Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea) | □ | □ | _____ |
| Urinary problems (e.g., pain or discomfort, bladder infections) | □ | □ | _____ |
| Skin disease (e.g., rashes, eczema, dermatitis) | □ | □ | _____ |
| Musculoskeletal problems (e.g., muscle aches, arthritis, swollen joints) | □ | □ | _____ |
| Neurologic problems (e.g., numbness, weakness, paralysis, headache) | □ | □ | _____ |
| Psychiatric problems (e.g., depression, anxiety) | □ | □ | _____ |

7. Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?
   □ YES □ NO If YES, please explain: _____
8. Do you smoke? □ YES □ NO How much? _____ Drink alcohol? □ YES □ NO How much?_____

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□ Reviewed by (Dr. Signature) _____ Date _____