

## ADULT PATIENT HISTORY & REGISTRATION

Welcome to our office! Please take a moment to fill out all of the following information to the best of your knowledge.

### PERSONAL INFORMATION

DATE \_\_\_\_\_

Patient Name: _____	Sex: <input type="checkbox"/> F <input type="checkbox"/> M	DOB: / /	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other
Patient Address: Street _____ Apt _____ City _____ State _____ Zip _____			
Email Address: _____		Home Phone: ( ) -	
Employer (if applicable): _____	Occupation: _____	Work Phone: ( ) -	
School (if applicable): _____		Cell Phone: ( ) -	
		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	

### MEDICAL HISTORY

Family Physician: _____	Phone: _____	Date of Last Physical Checkup: _____
Please list the names of current medications (Rx and Over the Counter), including vitamins, eye drops, and birth control pills: _____		Please list any allergies to medications, if applicable: _____
Have you ever been diagnosed or treated for the following?		
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Nerves
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Measles
<input type="checkbox"/> Cancer	<input type="checkbox"/> Head-trauma	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Serious Infections/Injuries
<input type="checkbox"/> Convulsions/seizure	<input type="checkbox"/> High Fever	<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid condition		<input type="checkbox"/> Allergies
Do you have a blood relative with any of the above conditions? <input type="checkbox"/> Y <input type="checkbox"/> N If Yes, please list the conditions and relationship of relative: _____		Do you ever been hospitalized? <input type="checkbox"/> Y <input type="checkbox"/> N If Yes, please provide details: _____

### EYE HISTORY

Date of Last Eye Exam: _____	I wear my glasses for: <input type="checkbox"/> Computer <input type="checkbox"/> Reading <input type="checkbox"/> TV <input type="checkbox"/> School	I wear contacts: _____ hrs/day Brand: _____ Type: _____
Have you ever been diagnosed or treated for the following?		Do you experience any of the following symptoms with your current eyeglass prescription?
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Blurry vision
<input type="checkbox"/> Corneal Abrasion	<input type="checkbox"/> Iritis/Uveitis	<input type="checkbox"/> Burning
<input type="checkbox"/> Eye infection	<input type="checkbox"/> Lazy eye	<input type="checkbox"/> Tearing
<input type="checkbox"/> Eye injury	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Headaches
	<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Flash of light
	<input type="checkbox"/> Retinal Disease	<input type="checkbox"/> Double vision
	<input type="checkbox"/> Other eye disorders	<input type="checkbox"/> Crossed eye/eye turn
Do you have a blood relative with any of the above conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please list the conditions and relationship of relative: _____		<input type="checkbox"/> Trouble seeing at night
Please check all that apply. Do you...		
<input type="checkbox"/> Work at a computer?	<input type="checkbox"/> Have children?	
<input type="checkbox"/> Think you might benefit from thinner, lighter lenses?	<input type="checkbox"/> Have family members in need of eye care?	
<input type="checkbox"/> Have interest in a "test drive" of the latest contact lens designs?	<input type="checkbox"/> Wear bifocals?	
<input type="checkbox"/> Spend time outdoors? _____ hrs/wk	If YES, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Have prescription sunglasses?	If NO, would you like information on PROGRESSIVE lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Prefer not to wear your glasses at times?	<input type="checkbox"/> Wear contact lenses?	
<input type="checkbox"/> Want information on Laser Vision Correction surgery?	If YES, are you satisfied with the vision and comfort? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Have interest in a non-surgical approach to vision correction?	If NO, would you like information on contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Have more than 1 pair of current Rx glasses?		

Emergency Contact: Name: _____ Relationship: _____ Phone Number: ( ) -
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How did you hear about us? <input type="checkbox"/> Internet <input type="checkbox"/> Magazine <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Referred by _____ <input type="checkbox"/> Other _____
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I understand that I am financially responsible for all charges at time of service, and I authorize the use of this signature on all insurance submissions.
Signature of Responsible Party: _____ Relationship: _____ Date: _____

**PLEASE COMPLETE REVERSE SIDE**

## Adult Visual Efficiency Checklist

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Please estimate how often the above-named exhibits the behaviors on this list. Give a score of 1 if you *never* observe the behavior. Give a score of 5 if the behavior *always* occurs.

**BEHAVIOR**

**ALWAYS** **NEVER**

1.	Do you sometimes have blurred vision?	1	2	3	4	5
2.	Do you get tired or fall asleep while reading or using the computer?	1	2	3	4	5
3.	Do you lose your concentration while reading?	1	2	3	4	5
4.	Does your vision seem worse at the end of the day?	1	2	3	4	5
5.	Do you experience double vision?	1	2	3	4	5
6.	Do you often close one eye while reading?	1	2	3	4	5
7.	Do your eyes feel "tired" at the end of the day?	1	2	3	4	5
8.	Do words seem to "run together" or appear blurry when reading?	1	2	3	4	5
9.	When reading, do you skip or repeat lines?	1	2	3	4	5
10.	When you look up from reading, do objects appear blurred?	1	2	3	4	5
11.	Do you sometimes feel your eyes aren't "working together"?	1	2	3	4	5
12.	Does prolonged reading or close work give you headaches?	1	2	3	4	5
13.	Do you ever have car sickness?	1	2	3	4	5
14.	Is reading in a moving vehicle difficult?	1	2	3	4	5
15.	Do both of your eyes work equally well?	1	2	3	4	5
16.	Do you experience eyestrain?	1	2	3	4	5
17.	Do you lose your place when moving from copy to a screen?	1	2	3	4	5
18.	Do you hold a book close to your eyes (7 to 8 inches)?	1	2	3	4	5