

# South River Eye Care Pre-Registration

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ (If child) Parent or Legal Guardian's Name: \_\_\_\_\_

Driver's License Number: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ How did you find us? \_\_\_\_\_

Preferred Method of Payment:    Cash            Check            Visa            MasterCard            Debit

**VISION INSURANCE**-----

Do you have vision insurance: No Yes            Name of Insurance Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insurance Provider Phone Number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

**PRIMARY CARE DOCTOR**-----

Name of Medical Doctor: \_\_\_\_\_

Doctors Phone Number: (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

**MEDICAL HISTORY**-----

Do you have any allergies to medications? No Yes, if yes please explain: \_\_\_\_\_

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Are you pregnant and/or nursing? No Yes

Please check all conditions which you currently have or have had in the past:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> allergies (specify) _____ | <input type="checkbox"/> drug sensitivities | <input type="checkbox"/> heart disease         | <input type="checkbox"/> retinal disease     |
| <input type="checkbox"/> cataracts                 | <input type="checkbox"/> eye diseases       | <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> seizures            |
| <input type="checkbox"/> crossed eyes              | <input type="checkbox"/> eye injury         | <input type="checkbox"/> lazy eye              | <input type="checkbox"/> thyroid dysfunction |
| <input type="checkbox"/> diabetes                  | <input type="checkbox"/> glaucoma           | <input type="checkbox"/> other (specify) _____ |  |
| <input type="checkbox"/> drooping eyelid           | <input type="checkbox"/> headaches          | <input type="checkbox"/> prominent eyes        |  |

**FAMILY HISTORY** (parents, grandparents, siblings, children; living or deceased)

Please check all that apply:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment/disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SOCIAL HISTORY** (This is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive?  No  Yes, if yes do you have difficulty when driving?  No  Yes, if yes please describe: \_\_\_\_\_

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 illegal drugs?  No  Yes If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

**VISION HISTORY**

When was your last eye exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Where was it done: \_\_\_\_\_

Do you experience any of the following vision problems?  burning  eye strain  itching  light sensitivity  tearing  
 twitching eye lids  other \_\_\_\_\_

Are you having trouble with your present glasses or contact lenses?  No  Yes, if yes  at distance  at near

Do you currently wear glasses?  No  Yes, if yes are they for  distance  reading  bifocals  other \_\_\_\_\_  
If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you currently wear contact lenses?  No  Yes, if yes, what type of lenses?  rigid  soft  extended wear  other

Do you have a copy of your present contact lens prescription or their containers?  No  Yes

Have you ever worn contact lenses but have stopped wearing them?  No  Yes, if yes, why did you stop? \_\_\_\_\_

Are you interested in trying to wear contact lenses at this time?  No  Yes

**REVIEW OF SYSTEMS**

SYSTEM	NO	YES	?	SYSTEM	NO	YES	?
<b>Constitutional</b>				<b>Ears, Nose, Mouth, Throat</b>			
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Integumentary</b> (Skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b>				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eyes</b>				<b>Respiratory</b>			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Vascular/Cardiovascular</b>			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal</b>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary</b>			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Bones/Joints/Muscles</b>			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lymphatic/Hematologic</b>			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Endocrine</b>				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Allergic/Immunological</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<b>Psychiatric</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctors Signature

Date