DAVIS EYE CENTER
PATIENT REGISTRATION FORM

PATIENT INFORMATION Date: _____ /_____ /_____

Last Name: _____ First: _____ Middle: _____

I prefer to be called: _____

Date of birth: _____ /_____ /_____ Age: _____ Social Security Number: _____ /_____ /_____

Sex (circle one): M F Marital Status: _____single _____married _____widowed

Height: _____ Weight: _____

ADDRESS/PHONE/EMAIL

Home Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Work: _____

My preferred phone: _____ Is it ok to leave a detailed message (circle one): Y N

Email: _____

CONTACTS

Emergency contact name: _____

Relationship to patient: _____ Phone: _____

Spouse name: _____ Phone: _____

Caretaker name: _____ Phone: _____

Power of attorney: _____ Phone: _____

Employer: _____ Phone: _____

Please list any contacts we may discuss your care with: _____

INSURANCE

Primary Medical Insurance: _____

Name of Policy Holder: _____ Date of Birth: _____

Secondary Medical Insurance: _____

Name of Policy Holder: _____ Date of Birth: _____

Vision Insurance: _____

Name of Policy Holder: _____ Date of Birth: _____

Pharmacy Insurance: _____

Name of Policy Holder: _____ ID#: _____

DOCTORS and PHARMACY

Referred by (first and last name): _____

Specialty: _____ Phone: _____

Primary Care Doctor (first and last name): _____

Address: _____ Phone: _____

My preferred pharmacy name: _____

Street and City: _____ Phone: _____

MEDICAL INFORMATION

Medical Conditions – please check all that apply to you **_____None**

_____Anxiety
_____Arthritis, Rheumatoid
_____Arthritis, Osteoarthritis
_____Asthma
_____Atrial Fibrillation (irregular heartbeat)
_____Bone marrow transplantation
_____Benign prostatic hypertrophy (enlarged prostate)
_____Breast cancer
_____Colon cancer
_____COPD or Emphysema
_____Coronary artery disease (heart attack, coronary bypass surgery or stenting)
_____Depression
_____Diabetes, type I
_____Diabetes, type II
_____End stage renal disease (kidney failure, dialysis)
_____GERD (reflux)
_____Hearing loss
_____Hepatitis
_____Hypertension (high blood pressure)
_____HIV/AIDS
_____Hypercholesterolemia (high cholesterol)
_____Hyperthyroidism
_____Hypothyroidism
_____Leukemia
_____Lung cancer
_____Lymphoma
_____Prostate cancer
_____Radiation treatment
_____Seizures
_____Skin cancer
_____Stroke, TIA (mini-stroke)
_____Stroke, CVA (often with lasting deficits)
_____Other: _____

If you have Diabetes, how many years: _____ Hgb A1C: _____ Fasting blood sugar: _____

Past Surgeries – please list **_____None**

_____ _____
_____ _____
_____ _____
_____ _____

Ocular History – please check all that apply to you **_____None**

_____Amblyopia (lazy eye)
_____Cataract
_____Contact lenses
_____Diabetic retinopathy
_____Double vision
_____Dry eyes
_____Glasses
_____Other: _____

_____Glaucoma
_____Macular degeneration
_____Ophthalmic migraine
_____Retinal detachment
_____Retinal tear
_____Strabismus
_____Floaters

Date of last eye exam: _____

Ocular Surgery – please check all that apply to you and circle which eye **_____None**

_____Cataract surgery: R L
_____Eye muscle surgery: R L
_____Eyelid surgery: R L
_____Glaucoma surgery: R L
_____LASIK, PRK, or RK: R L
_____Other: _____

_____Laser surgery for glaucoma: R L
_____Laser for secondary cataracts: R L
_____Laser surgery for the retina: R L
_____Retina surgery: R L

Family History – please check all that apply to someone in your family and indicate who

_____Blindness: _____
_____Cancer: _____
_____Cataracts: _____
_____CVA (stroke): _____
_____Diabetes: _____
_____Other: _____

_____Glaucoma: _____
_____Heart disease: _____
_____Hypertension: _____
_____Macular degeneration: _____
_____Retinal detachment: _____

Allergies –please list, include reaction if known **_____No known allergies to medications**

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

Social History

Alcohol: _____No _____Yes and how much: _____
Smoking: _____never _____former _____current and how much: _____
Driving status: _____drives during day _____drives during night
Occupation/Place of work: _____

<u>Review of Systems</u> – please check if you currently have any of these complaints or conditions

_____Poor vision
_____Tearing
_____Redness
_____Eye pain
_____Itchy eyes
_____Photosensitivity/Sensitivity to light
_____Jaw pain
_____Scalp tenderness
_____Black out of vision in one eye
_____Loss of vision
_____Recent cold or flu-like symptoms
_____Fever
_____Chills
_____Weight loss
_____Stuffy nose
_____Ear ache
_____Cough
_____Dry mouth
_____Oral ulcers
_____Cold sores
_____Increase in blood pressure
_____Rapid heartbeat
_____Congestion
_____Wheezing
_____Shortness of breath
_____Upset stomach
_____Diarrhea
_____Constipation
_____Nausea/vomiting
_____Burning on urination
_____Urinary frequency
_____Incontinence
_____Sexually transmitted disease
_____Genital ulcers
_____Joint pain
_____Arthritis
_____Stiffness
_____ Muscle pain
_____Rash
_____Changing moles
_____Headache
_____Seizure
_____Stroke
_____Paralysis
_____Fainting/passing out
_____Anxiety
_____Depression
_____Insomnia
_____Increase or decrease in blood sugar
_____Thyroid abnormalities
_____Bleeding
_____Anemia
_____Allergies
_____Hay fever
_____Hives
_____None

By signing this, I agree that the information I am providing is accurate and complete as possible.

Signature: _____ Date: _____