Our Town Eye Care

Patient Registration/Information & Privacy Disclosure Form

Salutation	◇Mr. ◇Mrs. ◇Ms. ◇Miss ◇Dr. ◇Rev ◇Other _____				
Patient Name				**Nickname**	
Address					
Date of Birth		**Age**		**Birth State**	

Primary Language		**Sex**		**SS#**	
Race	◇White ◇American Indian/Alaskan Native ◇Asian ◇Black/African American ◇Native Hawaiian	**Ethnicity**	◇Non Hispanic or Latino ◇Hispanic or Latino ◇Unknown		
Occupation		**Employer**			
Spouse's Name		**Mother's Maiden Name**			
Primary Care Physician		**Preferred Pharmacy**			

Communication

Preference	**Email**	**◇None**
Home Phone #	**Work Phone #**	**Ext**
Cell Phone #	**Cell Phone Carrier**	

Patient/Family Health History

Do you have any special visual requirements for computers, work (safety glasses), sports, driving (night) or hobbies?

Do you wear? ◇ Eyeglasses ◇ Contacts			Do you have a spare pair of glasses?	◇ Yes	◇ No
Do you have sunglasses?	◇ Yes	◇ No	Do you use artificial tears?	◇ Yes	◇ No
Women: Are you pregnant?	◇ Yes	◇ No	Are you breast feeding?	◇ Yes	◇ No

Please indicate if any of these eye or medical conditions apply to you or a family member (blood relatives only).

Condition	You	Family Member	Condition	You	Family Member
Blindness	◇	◇	Retinal Detachment	◇	◇
Cataract	◇	◇	Eye Turn/Strabismus	◇	◇
Glaucoma	◇	◇	Keratoconus	◇	◇
Lazy Eye/Amblyopia	◇	◇	Headaches/Migraines	◇	◇
Macular Degeneration	◇	◇	Retinal Disease	◇	◇
Other _____	◇	◇			

Have you ever had:

◇ Glare/Halos Around Lights	◇ Burning/Itching/Allergies	◇ Eye Ache or Pain
◇ Flashes of Light	◇ Infection of the Eye or Lid	◇ Crusty/Gritty Feeling
◇ Loss of Vision in one eye	◇ Loss of central/side/top/bottom vision	◇ Double Vision
◇ Puffy Lids/Styes	◇ Distortion of Vision	◇ Mucous discharge from eye
◇ Watery Eyes	◇ Pink Eye/Red Eye	◇ Something in eye
◇ Floaters	◇ Droopy Eyelids	◇ Dry Eyes
◇ Light Sensitivity	◇ Dyslexia	◇ ADD/ADHD

Acknowledgment of Receipt

I acknowledge that I have been offered/received a copy of Our Town Eye Care's Notice of Privacy Practices:

_____ _____

Patient Signature Date

Updated: _____ _____ _____ _____ _____ _____ _____

Review of Systems: Please indicate below if you have or have an ongoing problem with the following conditions or symptoms:

Cardiovascular	**Neurological**	**Respiratory**	**Hematologic/Lymphatic**
◇ **None**	◇ **None**	◇ **None**	◇ **None**
◇ Stroke	◇ Bell's Palsy	◇ Tuberculosis	◇ Swollen Glands
◇ Angina	◇ Multiple Sclerosis	◇ Asthma/Bronchitis	◇ Anemia
◇ High Blood Pressure	◇ Vertigo	◇ Sleep Apnea	◇ Leukemia/Lymphoma
◇ Heart Attack	◇ Epilepsy	◇ Sarcoid	◇ Bleeding/Blood Disorder
◇ Heart Disease	◇ Tremors/Seizures/Blackouts	◇ Emphysema	◇ Lyme Disease
◇ High Cholesterol	◇ Numbness/Weakness	◇ COPD	
◇ Vascular Disease		◇ Upper Respiratory Inf	
Ear, Nose & Throat	**Allergic/Immunologic**	**Muscle/Skeletal**	**Endocrine/Glands**
◇ **None**	◇ **None**	◇ **None**	◇ **None**
◇ Hearing Loss	◇ Food Allergy	◇ Arthritis	◇ Diabetes
◇ Tinnitus	◇ Seasonal Allergy	◇ Bruise Easily	◇ Hormone Dysfunction
◇ Nose Bleeds	◇ Environmental/Other Allergy	◇ Ankylosing Spondylitis	◇ Pituitary Dysfunction
◇ Dry Mouth	◇ Rheumatoid Arthritis/Lupus	◇ Joint/Muscle Pain	◇ Thyroid Dysfunction
◇ Sinusitis	◇ Autoimmune Disorder/Sjogrens		
Gastrointestinal	**Genital/Urinary**	**Psychiatric**	**Skin/Integumentary**
◇ **None**	◇ **None**	◇ **None**	◇ **None**
◇ IBD/Colitis/Crohn's	◇ Kidney Disease	◇ Anxiety/Depression	◇ Eczema/Psoriasis
◇ Acid Reflux/Ulcer	◇ HIV Positive/Aids	◇ Schizophrenia	◇ Rosacea
◇ Liver Disease/Hepatitis	◇ Herpes/Chlamydia	◇ Panic Episodes	◇ Itchiness/Dryness/Rashes
	◇ Blood in Urine		

Tobacco Use: ◇ Current Smoker ◇ Former Smoker #/Day _____

Please list all your **current medications** (include over the counter, vitamins and herbal therapy):

List any **allergies to medications**:

List all **major surgeries** in the last 5 years (including eye and laser surgery):

Informed Consent Regarding My Medical Condition

I authorize Our Town Eye Care to discuss my medical condition with family members listed below: (If none listed, no information will be given out.)

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Patient Signature Date

Updated: _____ _____ _____ _____ _____ _____ _____