

**BURKS VISION CLINIC**  
**Patient Registration and Medical History sheet**

06-07-2010

**PERSONAL INFORMATION:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Sex: M F

E-Mail \_\_\_\_\_ Social Security Number \_\_\_\_\_ Referred by \_\_\_\_\_

Race: African American Asian Caucasian Native American Hispanic Martial Status: Single Divorced Married Widowed

**EMPLOYMENT INFORMATION:**

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_  
STREET CITY STATE ZIP

**RELATIVE INFORMATION:**

Name of Spouse or nearest relative \_\_\_\_\_ Spouse Father Mother Child Other  
(CIRCLE ONE)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**INSURANCE INFORMATION: \*\* PLEASE SHOW INSURANCE CARDS \*\***

1. Insurance Company \_\_\_\_\_ ID number \_\_\_\_\_ Group Number \_\_\_\_\_

2. Insurance Company \_\_\_\_\_ ID number \_\_\_\_\_ Group Number \_\_\_\_\_

**I authorize release of any medical information necessary to process any insurance claim. I also authorize release of payments for medical benefits to my physician, if applicable. I understand that my insurance is a contract between me and my insurance carrier, and I assume responsibility for any balance due. In the absence of insurance, I assume responsibility for my bill.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\* I acknowledge receipt of the Notice of Privacy Practices\*\***

**Medical History**

Current Family Physician \_\_\_\_\_

Any allergic reactions to medication or other substances?  Yes  No If yes, explain: \_\_\_\_\_

List any current systemic illness (diabetes, high blood pressure, etc.) and current treatment with medications: \_\_\_\_\_

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

Have you been diagnosed with? CROSSED EYE LAZY EYE GLAUCOMA RETINAL DISEASE CATARACTS EYE INJURY NONE  
(Please circle)

Have you ever had general eye or refractive eye surgery?  Yes  No Explain: \_\_\_\_\_

Do you wear glasses?  Yes  No Date last Eye Exam? \_\_\_\_\_ How old is current prescription? \_\_\_\_\_

Do you wear contacts?  Yes  No How old is your present pair of contact lenses? \_\_\_\_\_

Type of contacts: Soft Disposable Rigid Extended Wear other ► Brand name of contacts? \_\_\_\_\_

**← Please turn this form over and complete reverse side →**

**Family History** Have any of your relatives (living or deceased) had any of the conditions listed below?

Table with 4 columns: Ocular Disease/Condition, Yes, No, Relationship to You, Explain:
Ocular Disease/Condition: Blindness, Cataract, Crossed Eyes, Glaucoma, Macular Degeneration, Retinal Detachment/Disease
Systemic Disease/Condition: Arthritis, Cancer, Diabetes, Heart Disease, High Blood Pressure, Lupus, Thyroid Disease, Other

**Review of Systems** Do you currently or have you ever had any problems in the following areas?

Table with 6 columns: Constitutional, Allergic, Cardiovascular, Respiratory, Eyes, Gastrointestinal, Genitourinary, Integumentary(Skin), Musculoskeletal, Neurological, Psychiatric, Endocrine, Ears, Nose, Mouth, Throat, Hematological/Lymphatic. Each cell contains a list of conditions and a 'none' checkbox.

PLEASE EXPLAIN ANY CONDITIONS LISTED ABOVE: \_\_\_\_\_

**Social History** This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.

Do you drive  Yes  No If yes, do you have visual difficulty driving?  Yes  No If yes, please explain: \_\_\_\_\_

Do you use tobacco products?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, please circle: rarely occasionally monthly weekly daily

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