BURKS VISION CLINIC

Patient Registration and Medical History sheet 02-02-2016

PERSONAL INFORMATION:

Name_____ Date of Birth_____Today's Date_____

Address_____City_____State_____Zip_____

Cell Phone_____ Home Phone_____ Work Phone_____ Sex: M F

E-Mail_____ Social Security Number_____

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

COMMUNUNICATION PREFERENCE: Telephone Email Postal **Ok to Text:** Yes No

EMPLOYMENT INFORMATION:

Employed By_____ Occupation_____

Address _____
STREET CITY STATE ZIP

RELATIVE INFORMATION: (CIRCLE ONE)

Name of Spouse or nearest relative _____ Spouse Father Mother Child Other

Cell Phone_____ Home Phone_____ Work 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 is 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 DISESASE 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?

Ocular Disease/Condition	Yes	No	Relationship to You	Explain:
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?

Constitutional none___
- ☐ developmental disability
- ☐ weight loss\gain
- ☐ fatigue
- ☐ other

Allergic/Immunologic none___
- ☐ environmental allergy
- ☐ rheumatoid arthritis
- ☐ lupus
- ☐ other

Cardiovascular none___
- ☐ heart disease
- ☐ hypertension
- ☐ stroke
- ☐ vascular disease
- ☐ other

Respiratory none___
- asthma
- bronchitis/emphysema
- COPD
- other

Gastrointestinal none___
- ☐ Crohn's
- ulcer
- ☐ colitis
- ☐ other

Genitourinary none___
- ☐ kidney/urinary tract
- ☐ other/medications
- ☐ other

Musculoskeletal none___
- ☐ fibromyalgia
- ☐ bone/joint pain
- ☐ ankylosing spondylitis
- other

Integumentary(Skin) none___
- ☐ rosacea
- eczema or psoriasis
- other

Neurological none___
- ☐ Multiple Sclerosis
- ☐ Epilepsy/seizures
- ☐ other

Psychiatric none___
- depression
- ☐ bipolar
- ☐ schizophrenia
- ☐ other

Endocrine none___
- ☐ diabetes
- ☐ thyroid disease
- other

Ears, Nose, Mouth, Throat none ___
- upper respiratory tract infections
- ☐ sinus congestion
- ☐ other

Hematological/Lymphatic none___
- ☐ anemia
- large volume blood loss
- ☐ other

Eyes none___
- ☐ loss of vision
- ☐ double vision
- ☐ itching
- ☐ glare/light sensitivity
- ☐ Blurred vision
- ☐ dryness
- ☐ foreign body sensation
- ☐ excess tearing/watering
- ☐ distorted vision/halos
- redness
- ☐ sandy/gritty feeling
- ☐ flashes/floaters in vision
- loss of side vision
- ☐ mucus discharge
- ☐ burning
- eye pain/soreness

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