BURKS VISION CLINIC

Patient Registration and Medical History sheet 04-03-2018

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