CRYSTAL VISION CLINIC

Patient Registration

Date: ____/____/____

Last Name_____ First Name_____ MI_____

Preferred Name:_____ Date of Birth:____/____/____

Sex: M / F Spouses name/or if child Parent(s) Name:_____

Address:_____City:_____ State:____ Zip:_____

Home Ph:( )_____ Work Ph:( )_____ Cell Ph:( )_____

How do you prefer we contact you? □Home Phone □Work Phone □Cell Phone □E-mail

Can we leave a message? □Yes □No Email Address:_____

Employer/School:_____ Occupation/School Grade:_____

Sports/Hobbies:_____ Who referred you to our office?_____

Ethnicity: □Caucasion □African American □Asian □Hispanic □American Indian □Other_____

Primary Language: □English □Chinese □Korean □Spanish □Vietnamese □Other_____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_____

Date of Last Eye Exam:____/____/____ Clinic/Eye Doctor's Name:_____

Do you wear glasses? Yes No All the time Occasionally Office Work Reading only Driving only

Do you wear contacts? Yes No Brand:_____ Replace Schedule:_____

Have you ever had eye injuries? Yes No Which Eye?_____

Have you ever had eye surgeries? Yes No Why?_____

Are you taking eye medications/drops? Yes No Why?_____

Are you currently pregnant Yes No Are you currently nursing Yes No

HAVE YOU EVER BEEN DIAGNOSED WITH?

Cataracts: Yes No When were you diagnosed?_____

Glaucoma: Yes No When were you diagnosed?_____

Macular Degeneration: Yes No When were you diagnosed?_____

Amblyopia (lazy eye): Yes No When were you diagnosed?_____

Strabismus (eye turn): Yes No When were you diagnosed?_____

PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE

CHIEF COMPLAINT: How can we help you today? In this space please circle/explain any signs/and or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as vision loss, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

Blurred Vision - Distance/Near	Eye Strain	Floaters or Spots	Headaches
Burning/Itchy Eyes	Watery Eyes	See Flashes	Migraine Headaches
Double Vision	Dry Eyes	See Halos	Loss of Vision
Mucous Discharge	Red Eyes	Poor Night Vision	Crossed Eyes
Eye Infections	Droopy Lids	Poor Color Vision	Light Sensitive
Sandy/Gritty Feeling	Tired Eyes	Eye Pain/Soreness	Wandering Eye

Other *(explain)*:

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS): PLEASE CHECK YES IF ANY OF THE FOLLOWING APPLIES TO YOU. IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK NONE.

Cardiovascular: __None __High Blood Pressure __Stroke, Location:_____ __Heart Disease __High Cholesterol Other_____	**Endocrine:** __None __Non-Insuline Dependent Diabetes __Insulin Dependent Diabetes __Thyroid Problem __Hormonal Dysfunction Other_____	**Respiratory:** __None __Asthma __Emphysema __COPD Other_____
Constitutional: __None __Cancer, Type:_____ __Trauma/Large Volume Blood Loss __Developmental Disability Other_____	**Genitourinary:** __None __Kidney Disease __Urinary Tract Infection __STD - name_____ Other_____	**Psychiatric:** __None __ADHD __Depression __Schizophrenia Other_____
Neurological: __None __Multiple Sclerosis __Epilepsy __Tumor Other_____	**Musculoskeletal:** __None __Osteoarthritis __Fibromyalgia __Gout Other_____	**Immunologic:** __None __AIDS or HIV __Rheumatoid Arthritis __Lupus Other_____
Hematological: __None __Anemia __Sickle cell disease/trait Other_____	**Gastrointestinal:** __None __Crohn's __Ulcerative Colitis Other_____	**Ear/Nose/Throat:** __None __Hearing Loss __Upper Respiratory Infection Other_____
Dermatologic: __None __Eczema __Rosacea __Psoriasis Other_____	**Allergies (please list)** __None Drug: Environmental:	**Alcohol Use:** Y N Amount: **Tobacco Use:** Former Y N Amount: Number of years:

Please list any medications and/or drugs that you are taking (including herbal) :

1)	For	6)	For
2)	For	7)	For
3)	For	8)	For
4)	For	9)	For
5)	For	10)	For

FAMILY HISTORY: Has anyone in your family, living or deceased, (example: Paternal grandmother, sister, etc) ever been diagnosed with:

DISEASE / CONDITION		WHO			WHO
Retinal Detachment:	Yes/No	_____	Cataracts:	Yes/No	_____
High Blood Pressure:	Yes/No	_____	Glaucoma:	Yes/No	_____
Diabetes:	Yes/No	_____	Crossed Eyes:	Yes/No	_____
Blindness:	Yes/No	_____	Macular Degeneration:	Yes/No	_____

__Adopted with no knowledge of family history

Other:_____

Reviewed by:

Dr. _____ *Date* _____