New Patient Routine Exam Registration Form

1. NEW PATIENTS: Please enter information for all fields.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Divorced ○ Widowed

Address: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Occupation: _____ Employer: _____

Have you been to our office before:
○ Yes ○ No

How did you hear about us? _____

Reason for today's visit: _____

Do you wear contacts:
○ Yes ○ No

If so, what type: _____

Personal Health History:
☐ High blood pressure ☐ Diabetes ☐ High Cholesterol ☐ Neurologic Condition ☐ Stroke ☐ Headaches
☐ Asthma or Breathing Conditions ☐ Ear/Nose/Throat Conditions ☐ Environmental/Seasonal Allergies
☐ Heart Disease/Heart Conditions ☐ Bleeding Disorders ☐ Kidney Conditions
☐ Liver Conditions or Hepatitis ☐ Urinary Conditions ☐ Autoimmune Conditions ☐ HIV ☐ Cancer

Personal Eye History:
☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Strabismus ☐ Retinal Disorders ☐ Dry Eye
☐ Corneal Disease ☐ Amblyopia ☐ Eye Injury ☐ Eye Surgery

Family (blood relatives) Eye History:
☐ Glaucoma ☐ Macular Degeneration ☐ Strabismus ☐ Retinal Disorders ☐ Dry eye ☐ Corneal Disease
☐ Amblyopia

Please list your current prescription medications, over the counter medications, and eye drops: _____

Are you allergic to any medications?
○ Yes ○ No

If yes, please list: _____

Are you pregnant?	Do you smoke?	If yes, how many packs per day:	Do you drink alcohol?	How often do you drink?
○ Yes ○ No	○ Yes ○ No	_____	○ Yes ○ No	_____