Seacoast Vision Care Patient Registration

Patient Name: _____ **Date of Birth:** __/__/____
(Legal Name) First M.I. Last

Mailing Address: _____
Street City State Zip

Cell Phone: (____) _____ **Home Phone:** (____) _____

Email: _____ ▫ Decline Email

Preferred method of contact? ▫ Cell Phone ▫ Home Phone ▫ Email

Parent/Guardian (*if under 18*): _____
Full Name Relationship

Eye Wellness Screening

▫ **Yes, I agree to an Eye Wellness Screening at today's appointment.**

▫ **No, I decline an Eye Wellness Screening.**

An Eye Wellness Screening captures imaging of your eye, which can detect eye health conditions. These conditions can include macular degeneration and glaucoma. Dr. Corbell recommends having this screening once per year at your annual exam to assess any abnormalities or changes from the prior year's evaluation.
The fee for the Eye Wellness Screening is $40 and is paid at the time of your visit.

Health History

Primary Care Physician: _____

Pharmacy: _____
Name *Location*

Do you take medications? ▫ No ▫ Yes *(*If "yes" please provide a list*)*

_____

Do you have allergies to medication(s) or food? ▫ No ▫ Yes *(*If "yes" please provide a list*)*

_____

General Health History: *(Please check all boxes that apply to your current or past health history)*

▫ Ear/Nose/Throat Problems	▫ High Blood Pressure	▫ Diabetes	▫ Heart Condition
▫ Stroke	▫ Asthma	▫ Tuberculosis	▫ Kidney Disease
▫ Muscle/Joint Pain	▫ Arthritis	▫ Fibromyalgia	▫ Rosacea/Skin rashes
▫ Headaches/Migraines	▫ HIV/AIDS	▫ Seizures	▫ Multiple Sclerosis
▫ MRSA Infection	▫ Anxiety/Depression	▫ High Cholesterol	▫ Thyroid Condition
▫ Anemia/Blood Disorder	▫ Hepatitis	▫ Cancer	▫ Concussion (what year?)

Are there any other medical conditions or past surgeries we should know about?

_____

Please complete other side of form.

Social History:

Use Tobacco?	▫ Yes	▫ No	**Use Alcohol?**	▫ Yes	▫ No
Use Cannabis?	▫ Yes	▫ No	**Use Illegal Drugs?**	▫ Yes	▫ No
Do You Drive? ▫ Yes	▫ No		**Occupation?** _____		

Ocular History

What is the reason for your visit today? _____

When was your last eye exam? _____

Who was your previous optometrist? _____

Do you wear eye correction now: ▫ Glasses ▫ Contact Lenses ▫ Both

What activities do you wear eye correction for:

▫ All day wear	▫ Driving	▫ Watching TV
▫ Reading	▫ Computer Use	▫ Work
▫ Sports/Outdoor Activities		

If you wear contact lenses, what brand do you wear? _____

Eye Symptoms: *(Please check all boxes that apply to your current or past vision history)*

▫ Loss of Vision	▫ Blurred Distance Vision	▫ Blurred Near Vision	▫ Distorted Vision/Halos
▫ Loss of Side Vision	▫ Double Vision	▫ Night Vision Problems	▫ Color Vision Problems
▫ Dryness	▫ Mucous Discharge	▫ Redness	▫ Itching
▫ Burning	▫ Excess Tearing/Watering	▫ Glare/Light Sensitivity	▫ Sties or Chalzion
▫ Eye Pain or Soreness	▫ Sandy or Gritty Feeling	▫ Tired Eyes	▫ Flashes in Vision
▫ Floaters in Vision	▫ Chronic Infection of Eye or Lid		

Eye Disease History: *(Please check all boxes that apply to your current or past vision history)*

▫ Crossed Eyes	▫ Lazy Eyes	▫ Drooping Eyelid	▫ Prominent Eyes
▫ Glaucoma	▫ Retinal Disease	▫ Retinal Detachment	▫ Macular Degeneration
▫ Cataract Surgery	▫ Diabetic Retinopathy	▫ Iritis	▫ Eye Infections
▫ Iritis	▫ Other: _____		

Have you previously had eye surgery or an eye injury? _____

Do you use any eye drops or medications? _____

Family History: ▫ Glaucoma ▫ Cataracts ▫ Macular degeneration ▫ Retinal Detachment ▫ Lazy eye