Registration and Medical History Questionnaire for Dr. Kent Voyce's Office

Name: _____ Today's Date: _____/_____/20____

Address: _____ Home Phone: _____

_____ Work/Cell Phone:_____

Last Exam Date ____/____/_____ By Whom: _____ Birth Date: ____/____/____

Name of Medical Doctor: _____ Personal Email: _____

Employer/Occupation:_____

How did you hear about our office? _____

Medical History

Do you have any allergies to medications? no yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, eye drops, over the counter medications and home remedies)

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had (including eyes or vision correction surgery):

_____

Circle any of the following that you have had: crossed eyes lazy eye drooping eyelid prominent eyes
Glaucoma retinal disease cataracts eye infections/ injury

Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____
Would you like to be fit for contact lenses? no yes
Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____
Type of contact lenses: Rigid Soft Brand_____ Solution _____
Do you sleep in your contacts? no yes Avg. # days before removal/cleaning _____
Avg. # days before disposing _____

Family History

Please note any family history(parents, grandparents, siblings, children; living or deceased)for the following conditions (not including you):

Disease/Condition	Yes	No	Relationship to You
Glaucoma			
Macular Degeneration			
Retinal Disease			
Blindness			
Cataract(s)			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Thyroid Disorder			
Other Heritable Disease			

Please complete page two

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Does your vision limit your ability to drive? no yes

Do you use tobacco products? no yes If yes, type/amount/how long?_____

Do you drink alcohol? no yes If yes, type/amount/how long? _____

Review of Systems Do you currently, or have you ever had, any problems in the following areas:

(Please **CIRCLE** and/or explain)	YES	NO	**EXPLAIN/DETAILS**
EYES (loss of vision, blurred vision, distorted vision/halos, sandy or gritty feeling, tired eyes, double vision, dryness, mucous drainage, redness, burning, itching, foreign body sensation, eye pain, soreness, chronic infection, excessive tearing/watering, styes, flashes or floaters in vision)			
ALLERGY/IMMUNOLOGIC (herpes, hay fever, lupus)			
BONES/JOINTS/MUSCLES (rheumatoid arthritis, joint pain, osteoporosis, osteoarthritis)			
CONSTITUTIONAL (fever, fatigue, weight loss/gain, sleep problems)			
EARS, NOSE, MOUTH, THROAT (allergies/hay fever, hearing loss, sinus congestion, post-nasal drip, dry throat/mouth)			
ENDOCRINE (diabetes, thyroid/other glands)			
GASTROINTESTINAL (acid reflux, diarrhea, constipation, hepatitis, gallbladder disorder)			
GENITOURINARY (kidney stones, incontinence, prostate disorder)			
INTEGUMENTARY (skin, acne, psoriasis)			
LYMPHATIC/HEMATOLOGIC (anemia, bleeding problems)			
NEUROLOGICAL (headaches, migraines, seizures, Bell's Palsy)			
PSYCHIATRIC (anxiety, depression, ADD, Alzheimers)			
RESPIRATORY (asthma, chronic bronchitis, emphysema)			
VASCULAR/CARDIOVASCULAR (elevated cholesterol, heart attack, Heart pain, high blood pressure, stroke, vascular disease)			
FEMALES Are you pregnant or nursing?			

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

_____

_____ _____

Patient's Signature Date

_____ _____

Doctor's Signature Date