Patient Registration Form

Date: _____

Last Name: _____ First Name: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: _____ Age: _____ Date of Birth: _____ Marital Status: _____

Cell Phone Number: _____ Email: _____

Occupation / Grade: _____ Employer / School: _____

Emergency Contact: Last Name: _____ First Name: _____

Relationship: _____ Cell Phone: _____ Email: _____

How did you find out about our office? _____

Insurance Information

Person Responsible for account: Last Name: _____ First Name: _____

Relationship to Patient: _____ Date of Birth: _____ SS#: _____

Please Provide front and back copies of your Vision and Medical Insurance Cards and Driver's License

Medical Insurance Company: _____ Contract #: _____

Subscriber Number: _____ Group #: _____

Vision Insurance Company: _____ Contract #: _____

Subscriber Number: _____ Group #: _____

Secondary Insurance

Insurance Company: _____ Contract #: _____

Subscriber Number: _____ Group #: _____

Assignment and Release

I, the undersigned, hereby authorize and direct my insurance carrier to pay directly to Professional Eye Care, Inc, dba Outreach Vision all primary and secondary insurance benefits due to me under my insurance plan. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. I acknowledge that the HIPPA notice of privacy practices has been made available to me and understand that it is available to view at outreachvision.com.

Patient Signature: _____ Date: _____

Patient Information

Patient Name _____ _____ _____
First Name Middle Initial Last Name

Date of Birth _____ Email Address: _____
☐ I do not have an email account

Gender: ☐ Male ☐ Female ☐ Other

Race: ☐ American Indian or Alaska Native ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ White
☐ Black or African American ☐ Other Race

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Who shall we contact in case of an emergency?

First Name _____ Last Name _____

Home Phone (_____) _____ Relationship: ☐ Single ☐ Married ☐ Widowed ☐ Separated

Work Phone (_____) _____ Cell Phone (_____) _____

Eye Surgeries

- IF YOU HAVE EVER HAD AN OPERATION ON YOUR EYES, PLEASE FILL OUT ALL OF THE REQUESTED INFORMATION.
- IF YOU HAVE HAD NO EYE SURGERIES, SELECT "NONE" IN THE 'NAME OF PROCEDURE BOX."

Date of Surgery _____ Surgeon _____

Name of Procedure:
☐ Cataract surgery
☐ Comeal Foreign Body
☐ Corneal Transplant
☐ Eye Muscle or Strabismus Surgery
☐ Eyelash Removal
☐ Retinal Detachment
☐ Eyelid Surgery
☐ Glaucoma Surgery
☐ Laser treatment of retina
☐ LASIK
☐ None
☐ Punctal Plugs
☐ RK

Family History

DO ANY OF YOUR FAMILY MEMBERS HAVE ANY OF THE CONDITIONS LISTED BELOW?
IF YES, CHECK ALL THAT APPLY:

	Sister	Mother	Father	Brother	Paternal Grandmother	Martial Grandmother	Paternal Grandmother	Maternal Grandmother
Family History of Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐
Eye Injury	☐	☐	☐	☐	☐	☐	☐	☐
Retina Disease	☐	☐	☐	☐	☐	☐	☐	☐
Other Eye Disease	☐	☐	☐	☐	☐	☐	☐	☐
Strabismus	☐	☐	☐	☐	☐	☐	☐	☐
Amblyopia	☐	☐	☐	☐	☐	☐	☐	☐
Blindness/ Vision Loss	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐

OTHER FAMILY HISTORY _____

_____

Questionnaire

Choose the appropriate age

☐ **I am 13 years old or younger**

☐ **I am 14 years old or older**

Health History

ENDOCRINE

Thyroid Disorder	☐ Yes	☐ No	Female hormone replacement therapy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Male hormone replacement therapy	☐ Yes	☐ No
Adrenal Disorder	☐ Yes	☐ No			

Other:

HEMATOLOGIC / LYMPHATIC

Anemia	☐ Yes	☐ No	Lymphoma	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No	Other Blood Disorders	☐ Yes	☐ No

Other:

CARDIOVASCULAR / HEART

Arrythmia / Irregular heart beat / palpitation	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Dysautonomia / POTS	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Syncope / Fainting	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Valve Replacement	☐ Yes	☐ No

Other:

NEUROLOGICAL

Cranial Nerve Palsy	☐ Yes	☐ No	Migraines	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No	Severe Headaches that aren't Migraines	☐ Yes	☐ No
Epilepsy / Seizures	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Feeling Uncoordinated	☐ Yes	☐ No	Vertigo	☐ Yes	☐ No

Other:

DOUBLE VISION ☐ Yes ☐ No

If yes, please answer the below questions:

1. Only at Near	☐ Yes	☐ No	2. Vertical	☐ Yes	☐ No
Only at Far	☐ Yes	☐ No	Horizontal	☐ Yes	☐ No
Both	☐ Yes	☐ No	Diagonal	☐ Yes	☐ No

EARS, NOSE AND THROAT

Benign Positional Vertigo / BPV / BPPV	☐ Yes	☐ No	Sensation of fluid leaking from Left ear	☐ Yes	☐ No
Fullness Left ear	☐ Yes	☐ No	Sensation of fluid leaking from Right ear	☐ Yes	☐ No
Fullness Right ear	☐ Yes	☐ No	Sinus Disorders	☐ Yes	☐ No
Meniere's Disease	☐ Yes	☐ No	Sinus Pain / Pressure	☐ Yes	☐ No
Ringing / Tinnitus in Left ear	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No
Ringing / Tinnitus in Right ear	☐ Yes	☐ No	TMJ problem	☐ Yes	☐ No

Other:

RESPIRATORY / LUNGS:

Asthma	☐ Yes	☐ No	Sarcoid	☐ Yes	☐ No
COPD	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No			

Other:

STOMACH / INTESTINES:

Crohn's Disease	☐ Yes	☐ No	Ulcerative Colitis	☐ Yes	☐ No
Irritable Bowel Syndrome	☐ Yes	☐ No	Diarrhea		
Nausea	☐ Yes	☐ No			

Other:

INTEGUMENT / SKIN

Skin Rash	☐ Yes	☐ No	Excessive Sweating	☐ Yes	☐ No
Eczema	☐ Yes	☐ No			

Other:

BONES / JOINTS / MUSCLES

Rheumatoid Arthritis	☐ Yes	☐ No	Cerebral Palsy	☐ Yes	☐ No
Polymyalgia	☐ Yes	☐ No	Neck Pain	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No	C-spine Fracture	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No	C-spine Fusion	☐ Yes	☐ No

Other:

ALLERGIC / IMMUNOLOGIC

Seasonal Allergies	☐ Yes	☐ No	Anaphylactic Reactions	☐ Yes	☐ No
HIV	☐ Yes	☐ No			

Other:

PSYCHIATRIC

Depression	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Panic episodes	☐ Yes	☐ No	Agoraphobia	☐ Yes	☐ No
PTSD (Post Traumatic Stress Disorder)	☐ Yes	☐ No	ADD / ADHD (Attention Deficit Disorder/ Attention Deficit Hyperactivity Disorder)	☐ Yes	☐ No

Other:

GENITALS / KIDNEY / BLADDER

Frequent Urination	☐ Yes	☐ No	Kidney Transplant	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No			

Other:

CONSTITUTION

Fatigue	☐ Yes	☐ No	Chills	☐ Yes	☐ No
Fever	☐ Yes	☐ No	Insomnia	☐ Yes	☐ No

Other:

History of Cancer ☐ Yes ☐ No

If YES, list what kind(s):

Social History

Are you or have you been a smoker? ☐ Yes ☐ No

Check one:

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker

Do you drink alcohol? ☐ Yes ☐ No

Check one:

- ☐ Social drinker
- ☐ Light drinker - 1-2u/day
- ☐ Moderate drinker - 3-6u/day
- ☐ Heavy drinker - 7-9u/day

Do you misuse/abuse drugs or medications? ☐ Yes ☐ No

Check all that apply:

☐ Recreational drug user	☐ Crack	☐ Methamphetamine
☐ Cannabis	☐ Heroin	☐ Oxycontin
☐ Cocaine	☐ LSD	☐ Speed

Other: _____

Occupation or Grade in school _____

Hobbies _____

_____

_____

_____

General History

Last Eye Exam _____ (MM/DD/YYYY) **Dr Last Eye Exam** _____

DO YOU WEAR GLASSES?

☐ Yes ☐ No

If yes, please answer the below questions:

Age when glasses were first worn (in years): _____

Worn full or part time? (choose one):

Full Time	☐ Yes	☐ No
Part Time	☐ Yes	☐ No

Worn for far, near or both? (choose one):

Far Vision Only	☐ Yes	☐ No
Near Vision Only	☐ Yes	☐ No
Both Far and Near	☐ Yes	☐ No

DO YOU WEAR CONTACT LENSES?

☐ Yes ☐ No

If yes, please answer the below questions:

Age when contacts first worn (in years): _____

Worn full time or part time? (choose one):

Full Time	☐ Yes	☐ No
Part Time	☐ Yes	☐ No

DO YOU WORK AT A DESK OR ON A COMPUTER?

☐ Yes ☐ No

If yes, please answer the below questions:

Approximate distance from your eyes to the desk / computer screen (in inches): _____

How many hours per day? _____

Are glasses worn? ☐ Yes ☐ No

DO YOU PERFORM DISTANCE VIEWING (10 FEET AND BEYOND - CLASSROOM, WORK, DRIVING)?

☐ Yes ☐ No

If yes, please answer the below questions:

How many hours per day? _____

Are glasses worn? ☐ Yes ☐ No

DIAGNOSIS OF AMBLYOPIA? ☐ Yes ☐ No

If yes, Check all that apply:

- ☐ Both Eyes
- ☐ One Eye
- ☐ Treatment Management: Eye Muscle Surgery
- ☐ Treatment Management: Glasses
- ☐ Treatment Management: Patching
- ☐ Treatment Management: Pharmaceutical
- ☐ Treatment Management: Vision Therapy

DO YOU HAVE OCULAR COMPLICATIONS RELATED TO DIABETES? ☐ Yes ☐ No

DIAGNOSIS OF DRY EYE? ☐ Yes ☐ No

If yes, Check your level of severity:

- ☐ Mild
- ☐ Moderate
- ☐ Severe

OTHER VISION SYMPTOMS

Eye itchiness	☐ Yes	☐ No	Flashes of light	☐ Yes	☐ No
Spuls / Floalers	☐ Yes	☐ No	Sudden loss of vision	☐ Yes	☐ No
Eye Dryness	☐ Yes	☐ No	Increased tearing	☐ Yes	☐ No
Gritty feeling in eyes	☐ Yes	☐ No	Redness	☐ Yes	☐ No
Watery eye	☐ Yes	☐ No	Trouble seeing at night	☐ Yes	☐ No
Burning eyes	☐ Yes	☐ No	Trouble working up close	☐ Yes	☐ No
Eye strain	☐ Yes	☐ No	Trouble being fit with, or adjusting to a prior pair of glasses	☐ Yes	☐ No
Sore eyes	☐ Yes	☐ No			

READING

Trouble learning at school, work or other activity ☐ Yes ☐ No

Trouble concentrating ☐ Yes ☐ No

Other Questions

HAVE YOU BEEN DIAGNOSED WITH A TRAUMATIC BRAIN INJURY (TBI)? ☐ Yes ☐ No

If yes, please answer the below questions:

Who diagnosed you as having a TBI?_____

When did the TBI occur? Date:_____

Are you coming to Vision Specialists to be evaluated for symptoms that seem to have been caused by or seem to be related to TBI?

☐ Yes ☐ No

If headaches are a problem for you, please list your 3 worst headache triggers:

1. _____ 2. _____ 3. _____

If dizziness is a problem for you, please list your 3 worst dizziness triggers:

1. _____ 2. _____ 3. _____

Are you currently driving a car during the day? ☐ Yes ☐ No

Are you currently driving a car at night? ☐ Yes ☐ No

1. OF ALL OF YOUR SYMPTOMS, CHECK THE SYMPTOM THAT IS THE WORST AND CAUSES YOU THE MOST PROBLEMS:

- ☐ Dizziness
- ☐ Headache
- ☐ Anxiety
- ☐ Neck Pain / Ache
- ☐ Reading

2. HOW LONG HAVE YOU HAD THIS WORSTSYMPTOM? (IN YEARS)_____

3. HOW SEVERE IS YOUR WORST SYMPTOM, ON AN AVERAGE DAY, ON A 0-10 SCALE (WHERE 0 IS NO SYMPTOM AND 10 IS THE WORST IT COULD BE)?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

4. OF ALL OF YOUR SYMPTOMS, CHECK THE SYMPTOM THAT IS THE SECOND WORST:

- ☐ Dizziness
- ☐ Headache
- ☐ Anxiety
- ☐ Neck Pain / Ache
- ☐ Reading

5. HOW LONG HAVE YOU HAD THIS SECOND WORST SYMPTOM (IN YEARS)_____

6. HOW SEVERE IS YOUR SECOND WORST SYMPTOM, ON AN AVERAGE DAY, ON A 0-10 SCALE (WHERE 0 IS NO SYMPTOM AND 10 IS THE WORST IT COULD BE)?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

7. PLEASE ANSWER WHETHER YOU HAVE HAD ANY OF THESE TESTS PERFORMED:

Head CT	☐ Yes	☐ No	Electronystagmogram (ENG)	☐ Yes	☐ No
MRI/MRA	☐ Yes	☐ No	Other	☐ Yes	☐ No
Audiogram	☐ Yes	☐ No			

If Other list here:_____

8. PLEASE ANSWER WHETHER YOU HAVE SEEN ANY DOCTORS / SPECIALISTS / OTHER PROVIDERS FOR THESE SYMPTOMS?

Internist	☐ Yes	☐ No	Reading Specialist	☐ Yes	☐ No
ENT (Ears / Nose /Throat)	☐ Yes	☐ No	Psychiatrist / Psychologist	☐ Yes	☐ No
Chiropractor	☐ Yes	☐ No	Pediatrician	☐ Yes	☐ No
Family Practice	☐ Yes	☐ No	Ophthalmologist	☐ Yes	☐ No
Neurologist	☐ Yes	☐ No	Optometrist	☐ Yes	☐ No
PM&R (Physical Medicine and Rehab.)	☐ Yes	☐ No	Emergency Physician / ER	☐ Yes	☐ No

If Other list here:_____

Personal Medication List

Prescription Medications	Purpose or Reason Taken	Dose	Time(s) of Day	Form (Liquid, capsule, tablet)	Special Instructions
Over-the-Counter Medications	**Purpose or Reason Taken**	**Dose**	**Time(s) of Day**	**Form (Liquid, capsule, tablet)**	**Special Instructions**

Health Problems _____

Primary Doctor _____ **Doctor's Phone** _____

Local Pharmacy _____ **Pharmacy Phone** _____

Drug Allergies _____ **Your Phone** _____

Your Name _____ **Date** _____

Adapted by the American Society of Consultant Pharmacists (ASCP) Foundation
for the Center for Medicines & Healthy Aging

Instructions for Personal Medication List

- Write the name of each medication you take, the reason, the dose, etc.
- In the last column, write special instructions such as "with food," etc.
- In the over-the-counter section, include vitamins, nutritional supplements, pain relievers, antacids, laxatives and/or herbal remedies.
- Carry the list with you in a purse or wallet with your medical cards.
- Add new medicines when you start taking them.
- Make copies of the blank form so you can use it again as your medications change.
- To save paper, you may want to print this form front and back.

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for the Center for Medicines & Healthy Aging