Holly Springs EYE ASSOC. OD PA

Patient Registration & Medical History Form

(Please bring insurance cards, eyeglasses and contact lenses)

PATIENT INFORMATION			
Last Name:	First Name:		Middle Int.
Birth Date:	Age:	Gender: Male / Female	
Marital Status: Single / Married / Divorced / Widowed		Social Security #:	
Address:	City:	St:	Zip:
Mobile Phone: Text Opt-out ☐	Work Phone:	Home Phone:	
Email Address:			
Occupation:	Employer:		
Account responsibility if patient is a minor:			
How did you find us? Internet Search / Facebook / Signage / Print ad / Insurance	Referred by Patient? List Name...		

INSURANCE INFORMATION			
Policy Holder's Last Name:	Policy Holder's First Name:		Middle Int.
Policy Holder's Birth Date:	Policy Holder's Social Security #:		
Medical Insurance Name:	Member ID#:	Group #:	
Vision Plan Name:	Vision Plan ID#:		

MEDICAL HISTORY	
Name of Primary Care Provider:	Phone:
List All Medications:	
List Any Drug Allergies:	
List Any Surgeries, Type, Date:	

EYE HISTORY

(check all that apply) ☐ Cataract ☐ Diabetic eye ☐ Retinal detachment ☐ Cross eyes ☐ Surgery
☐ Glaucoma ☐ Macular degeneration ☐ Lazy eye ☐ Lazik/RK

Do you wear CONTACT LENSES? Y N Type: 2-week / monthly / toric / gas perm / color / other_____

If No, are you interested in contact lenses? Y N Are you interested in Laser Vision Correction? Y N

Do you wear EYEGLASSES? ☐ Full time ☐ Reading only ☐ Sports ☐ Sun protection
(If YES, for what activities?) ☐ Distance only ☐ Computer ☐ Recreation ☐ Backup for contacts

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply & list family member):

☐ Diabetes _____ ☐ High blood pressure _____
☐ Heart Disease_____ ☐ Cancer/Type_____

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply & list family member):

☐ Glaucoma _____ ☐ Macular Degeneration _____
☐ Strabismus_____ ☐ Retinal Detachment_____
☐ Amblyopia (lazy eye)_____

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas (check all that apply):

EYES
☐ Loss of vision
☐ Blurred vision
☐ Distorted vision/Halos
☐ Loss of side vision
☐ Double vision
☐ Dryness
☐ Mucous Discharge
☐ Redness
☐ Sandy or gritty feeling
☐ Itchiness
☐ Burning
☐ Foreign body sensation
☐ Excess tearing/watering
☐ Eye pain or soreness
☐ Chronic infection eye/lid
☐ Site or Chalazion
☐ Flashes/floaters

NEUROLOGICAL
☐ Headaches
☐ Migraines
☐ Seizures

RESPIRATORY
☐ Asthma
☐ Chronic bronchitis
☐ Emphysema

VASCULAR/CARDIOVASCULAR
☐ Diabetes
☐ Heart pain
☐ High blood pressure
☐ Vascular disease

GASTROINTESTINAL
☐ Diarrhea
☐ Constipation

EAR/NOSE/MOUTH/THROAT
☐ Seasonal allergies
☐ Sinus congestion
☐ Runny nose
☐ Post nasal drip
☐ Chronic cough
☐ Dry throat/mouth

ENDOCRINE
☐ Thyroid
☐ Other glands

BONES/JOINTS/MUSCLES
☐ Rheumatoid arthritis
☐ Muscle pain
☐ Joint pain

LYMPHATIC/HEMATOLOGICAL
☐ Anemia

GENITOURINARY
☐ Genitals
☐ Kidney
☐ Bladder

INTEGUMENTARY
☐ Skin problems

☐PSYCHIATRIC

CONSTITUTIONAL
☐ Fever
☐ Weight loss/gain

Other medical conditions? _____

CONSENT FOR TREATMENT

I hereby authorize Holly Springs Eye Associates to administer diagnostic and medical procedures as may be necessary for proper health care.

Signature: _____ Date: _____

Printed Name of Patient: _____