

Patient Registration and History Questionnaire

MUST BE UPDATED AT EACH VISIT - PLEASE COMPLETE BOTH SIDES

Patient Name (Mr. Mrs. Ms Miss) _____ Date _____

Birthdate _____ Patients SSN: _____ Parent (if Child) _____

Address _____ Home PH# () _____

City _____ State _____ Zip _____ E-mail address: _____

Employer _____ Work PH # () _____

Occupation _____ Do you work on a computer? Y / N. _____ hr./day

Hobbies / Sports / Special Visual Demands: _____

Date of Last Eye Exam _____ Name of Last Eye Doctor _____ Phone # () _____

Date of Last Medical Exam _____ Name of Medical Doctor _____ Phone # () _____

Purpose of Today's Visit _____

Whom may we thank for referring you? _____

Do you wear glasses? Y / N. If yes, for Distance / Near / Both _____ How old are they? _____ Do you like wearing them? Y / N

Do you wear contact lenses? Y / N _____ If Yes, what type of contact lenses are you wearing? _____ Soft / Gas Permeable
Daily wear / Extended wear Disposable / Standard Astigmatism / Spherical Distance only / Monovision / Bifocal

If No, are you interested in contact lenses? Y / N _____ If Yes: [] Full time wear [] Occasional wear
[] Bifocal / Monovision [] Astigmatic [] Tinted (to change/ enhance eye color) [] Sports [] Reduce/ Maintain Rx

How old are your contact lenses? _____ What solutions do you use? _____

Have you had refractive surgery? Y / N _____ If No, are you interested in the procedure? Y / N

Family Health History (please check all that apply and state which relative)

Cataracts _____ Glaucoma _____ Blindness _____ Lazy/ Turned eye _____ Macular Degeneration _____ Retinal Detachment _____

Diabetes _____ High Blood Pressure _____ Heart Disease _____ Arthritis _____ Thyroid _____ Cancer _____

Headaches / Migraines _____ Other eye or health conditions: _____

Insurance and Payment Authorization

Today's Professional fees will be paid for by: Cash / Check _____ Credit Card _____ Medicare _____ Vision Insurance _____

Insurance Company: _____ ID# _____

I request that payment of authorized insurance benefits be made on my behalf to the Libertyville Vision Center. I authorize the release of information necessary to process claims. I permit my signature to be kept on file for future visits and insurance filings.

Due to the varying nature of vision and health insurance company plans, there may be additional fees or eligibility denials that my insurance dictates at the time of filing my insurance by the Libertyville Vision Center. I understand and agree that regardless of my insurance benefits, I (or my guarantor) am responsible to pay for the balance on my account for all professional services and materials provided. I understand that if payment is not made in a timely manner, I may incur late or collection fees on all overdue balances on my account.

Signature _____ Date _____

Patient Health History: Review of systems. Do you currently, or have you ever had problems in the following areas?

System	No	Yes	?
Constitutional			
Fever	___	___	___
Weight loss / gain	___	___	___
Cardiovascular			
Diabetes	___	___	___
High Blood Pressure	___	___	___
Vascular Disease	___	___	___
Heart Condition	___	___	___
Gastrointestinal			
Diarrhea	___	___	___
Constipation	___	___	___
Genitourinary			
Kidney	___	___	___
Bladder	___	___	___
Genitals	___	___	___
Neurological			
Headaches	___	___	___
Migraines	___	___	___
Seizures	___	___	___
Respiratory			
Asthma	___	___	___
Emphysema	___	___	___
Chronic Bronchitis	___	___	___
Hematological / Lymphatic			
Anemia	___	___	___
Bleeding problems	___	___	___
Ear, Nose, Mouth, Throat			
Allergies	___	___	___
Hay Fever	___	___	___
Sinus Congestion	___	___	___
Other	___	___	___
Bones / Joints / Muscles			
Rheumatoid Arthritis	___	___	___
Muscle pain	___	___	___
Joint pain	___	___	___
Allergic / Immunological			
___	___	___	___
Psychiatric			
___	___	___	___
Integumentary (skin)			
___	___	___	___
Endocrine			
Thyroid / other glands	___	___	___

System	No	Yes	?
Eyes			
Blurred vision at near	___	___	___
Blurred vision at Distance	___	___	___
Glare / Light sensitivity	___	___	___
Temporary Loss of Vision	___	___	___
Loss of Side Vision	___	___	___
Distorted Vision / Haloes	___	___	___
Double Vision	___	___	___
Mucous discharge	___	___	___
Dryness	___	___	___
Redness	___	___	___
Foreign body sensation	___	___	___
Sandy or Gritty feeling	___	___	___
Itching	___	___	___
Burning	___	___	___
Excess Tearing / Watering	___	___	___
Eye pain or Soreness	___	___	___
Chronic Infection of Eye or Lid	___	___	___
Sties or Chalazions	___	___	___
Flashes of light	___	___	___
Floaters / Spots in vision	___	___	___
Tired Eyes	___	___	___
Previous Eye Surgery	___	___	___
History of patching an Eye	___	___	___
Eye Exercises / Vision Therapy	___	___	___

If you answered yes to any of the above, or have a condition not listed

please explain: _____

Have you had any recent surgeries? Y / N If Yes, please explain: _____

Pediatric Patients only:

	No	Yes	?
Birth History Problems	___	___	___
Premature	___	___	___
Developmentally delayed	___	___	___
School age level appropriate	___	___	___

Please list all current medications: _____

Please list any drug allergies: _____

Social History: This information is kept strictly confidential.

Do you drive? Y N If Yes, do you have any visual difficulty when driving? Y N If Yes, Please explain: _____

Do you have any occupational concerns? Y N _____

Do you use Cigarettes / tobacco? Y N Do you use alcohol? Y N Do you use any other substances / recreational drugs? Y N

Have you been exposed to or infected with any infectious or immune diseases? Y N _____