Sunshine Eye Clinic - Patient Registration and Medical History

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

Address: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Communication Preference (circle): Text Phone Email

Birth Date: _____/_____/_____ Social Security Number: _____/_____/_____ Gender (circle): Male Female

Race (circle): White Black or African American Hispanic Asian None of these

Primary Care Physician: _____ Referring Doctor: _____

Do you wear glasses? ☐ Yes ☐ No If yes: ☐ Distance Only ☐ Near Only ☐ Progressive ☐ Lined Bifocal/Trifocal

Do you wear contacts? ☐ Yes ☐ No Wear Schedule: ☐ Daily ☐ Monthly ☐ 2 Week Brand: _____

Are you interested in wearing contacts? ☐ Yes ☐ No Have you worn contacts in the past? ☐ Yes ☐ No

Medical History

Do you currently have or have you ever had any problems in the following areas:

Yes	No	DISEASE/CONDITION	Yes	No	DISEASE/CONDITION
☐	☐	Blindness	☐	☐	High Blood Pressure
☐	☐	Cataracts	☐	☐	Diabetes
☐	☐	Crossed or Lazy Eye	☐	☐	Thyroid Disease
☐	☐	Dry Eye	☐	☐	Cholesterol
☐	☐	Floaters/Flashes	☐	☐	Arthritis
☐	☐	Glaucoma	☐	☐	Rheumatoid Arthritis
☐	☐	Macular Degeneration	☐	☐	Migraines
☐	☐	Eye Injury	☐	☐	HIV Positive/Aids
☐	☐	Eye Surgery	☐	☐	Pregnant or Breastfeeding

Explain eye injury/surgery: _____

_____

Family History

Yes	No	DISEASE/CONDITION
☐	☐	High Blood Pressure
		Relation to you: _____
☐	☐	Diabetes
		Relation to you: _____
☐	☐	Thyroid Disease
		Relation to you: _____
☐	☐	Cholesterol
		Relation to you: _____
☐	☐	Glaucoma
		Relation to you: _____
☐	☐	Macular Degeneration
		Relation to you: _____

Tobacco Use: ☐ Occasional Smoker ☐ Everyday Smoker ☐ Electronic Cigarette ☐ Former Smoker ☐ Never Smoker

Medications

Do you have any allergies to medications? ☐ Yes ☐ No Name of Medication(s): _____

Please list any medications you are taking and the condition you are taking them for:

Name of Medication	Condition	Name of Medication	Condition
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	