Valley Eye Institute

Patient Registration / Medical History Questionnaire

DEMOGRAPHICS

Name _____ SSN_____
Last First Middle

Street _____ City_____ State_____ Zip_____

Birth Date_____/_____/_____ Sex: ❑Male ❑Female Status: ❑Married ❑Divorced ❑Single ❑Widowed

Home Phone (___)_____-_____ Work Phone (____)_____-_____ Cell Phone (____)_____-_____

E-Mail Address _____

Employer _____
Name Address

Spouse:_____ Work Phone (____)_____-_____ Cell Phone (____)_____-_____

Emergency Contact_____ Emergency Phone (____)_____-_____

BILLING

Guarantor (Financially Responsible Person)_____
Last First Middle

Street _____ City_____ State_____ Zip_____

Relationship to Patient: Self_____ Spouse_____ Parent_____ Other_____

_____
Primary Insurance Policy Holder Policy ID SS# D.O.B

_____
Secondary Insurance Policy Holder Policy ID SS# D.O.B.

REFERRAL

Guarantor (Financially Responsible Person)_____
Last First Middle

Street _____ City_____ State_____ Zip_____

Relationship to Patient: Self_____ Spouse_____ Parent_____ Other_____

_____
Primary Insurance Policy Holder Policy ID SS# D.O.B

_____
Secondary Insurance Policy Holder Policy ID SS# D.O.B

Whom may we thank for telling you about our practice?_____

❑Friend/Family ❑Patient ❑Radio ❑Sign ❑Newspaper ❑Yellow Pages ❑MD/DO ❑Optometrist ❑Other

_____
Primary Care Doctor Address Phone

_____
Family Optometrist Address Phone

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List any medications & dosages you currently take (prescription and over-the-counter):

_____

_____

_____

_____

Do you have any allergies? ❑YES ❑NO

If YES, list:_____

_____

Do you currently have any problems in the following areas? If "YES", please provide information:

ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjögrens, etc.)	❑YES	❑NO	_____
CARDIOVASCULAR (Heart, blood pressure, stroke)	❑YES	❑NO	_____
GENERAL/CONSTITUTIONAL (Fever,weight loss, other)	❑YES	❑NO	_____
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc)	❑YES	❑NO	_____
ENDOCRINE (Diabetes, thyroid, etc.)	❑YES	❑NO	_____
EYES (glaucoma, cataract, retinal disease, etc).	❑YES	❑NO	_____
Loss of Vision	❑YES	❑NO	_____
Blurred Vision	❑YES	❑NO	_____
Fluctuating Vision	❑YES	❑NO	_____
Distorted Vision (halos)	❑YES	❑NO	_____
Loss of Side Vision	❑YES	❑NO	_____
Double Vision	❑YES	❑NO	_____
Dryness	❑YES	❑NO	_____
Mucous Discharge	❑YES	❑NO	_____
Redness	❑YES	❑NO	_____
Sandy or Gritty Feeling	❑YES	❑NO	_____
Itching	❑YES	❑NO	_____
Burning	❑YES	❑NO	_____
Foreign Body Sensation	❑YES	❑NO	_____
Excess Tearing/Watering	❑YES	❑NO	_____
Glare/Light Sensitivity	❑YES	❑NO	_____
Eye Pain or Soreness	❑YES	❑NO	_____
Infection of Eye or Lid (Blepharitis, Stye)	❑YES	❑NO	_____
Tired Eyes	❑YES	❑NO	_____
Crossed Eyes, Lazy Eye	❑YES	❑NO	_____
Drooping eyelid	❑YES	❑NO	_____
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc)	❑YES	❑NO	_____
GENITAL, KIDNEY, BLADDER	❑YES	❑NO	_____
BLOOD/LYMPH (Cancer, high cholesterol, anemia)	❑YES	❑NO	_____
SKIN (Dermatitis, skin cancer, etc.)	❑YES	❑NO	_____
MUSCLES, BONES JOINTS (Arthritis, etc)	❑YES	❑NO	_____
NEUROLOGICAL (Multiple sclerosis, headaches)	❑YES	❑NO	_____
PSYCHIATRIC (Anxiety, depression, insomnia)	❑YES	❑NO	_____
RESPIRATORY (Asthma, emphysema, bronchitis)	❑YES	❑NO	_____

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Please check if you have had the following:

❑Arthritis ❑Cataracts ❑Eye Condition ❑Glaucoma ❑Hypertension ❑Shortness of Breath ❑Sinus
❑Thyroid Disorders ❑Ulcer ❑Chicken Pox ❑Hernia ❑Measles ❑Polio ❑Venereal Disease ❑Hemorrhoids
❑Liver Disease ❑Mumps ❑Rheumatic Fever ❑Hepatitis ❑Malaria ❑Pancreatitis

List any other past medical problems:_____

List any past surgeries: (Tonsillectomy, Appendectomy):_____
_____

List any past ocular surgeries: (Cataract, LASIK, PRK, etc) _____
_____

FAMILY HISTORY M=mother F=father S=sibling GF=grandfather GM=grandmother:

Disease:	Yes or No:		Relationship to Patient:
Blindness	❑YES	❑NO	_____
Glaucoma	❑YES	❑NO	_____
Arthritis	❑YES	❑NO	_____
Cancer	❑YES	❑NO	_____
Diabetes	❑YES	❑NO	_____
Heart Disease or High Blood Pressure	❑YES	❑NO	_____
Kidney Disease	❑YES	❑NO	_____
Lupus	❑YES	❑NO	_____
Stroke	❑YES	❑NO	_____
Thyroid Disease	❑YES	❑NO	_____
Retinal Detachment	❑YES	❑NO	_____
Other	❑YES	❑NO	_____

SOCIAL HISTORY

Do you drink alcohol?	❑YES	❑NO	If YES: ❑Occasional ❑1/day ❑2-3/day ❑4+/day
Have you ever had a blood transfusion?	❑YES	❑NO	
Have you ever tried to wear contact lenses?	❑YES	❑NO	
Do you currently wear contact lenses?	❑YES	❑NO	If YES, how long? _____
Do you drive?	❑YES	❑NO	
Do you have visual difficulty when driving?	❑YES	❑NO	
Do you have problems with night vision?	❑YES	❑NO	
Do you currently wear glasses?	❑YES	❑NO	If YES, how long in current prescription?_____
Do you use illegal drugs?	❑YES	❑NO	
Do you smoke?	❑YES	❑NO	If YES: ❑Occasional ❑1 pack/day ❑2-3 pack/day ❑4+ packs/day

Employment Status: ❑Full-time ❑Part-time ❑Homemaker ❑Self-employed ❑Retired ❑Disabled ❑Unemployed
Marital Status: ❑Married ❑Divorced ❑Single ❑Widowed

Patient's Signature: _____ Date: _____