Looking Glass Optical

New Patient Registration and Health History Form

Patient's Name _____ Date_____
Parent or Responsible Person's Name _____ Age _____ Birth Date ____/____/___
Mailing Address _____ Home Tel. #_____
_____ Work Tel. # _____
Occupation _____ Cellular Tel. # _____
Employer _____ Email Address _____
Whom may we thank for referring you to us? _____
What is your reason for seeking care at this time?_____
_____
Name of Medical Insurance _____ Insurance Card # _____
Name of Vision Insurance _____ Insurance Card # _____

Health History

Review of Systems (Please **"x"** the appropriate column and **CIRCLE** conditions that apply)
Do you currently, or have you ever had any problems in the following areas:

	YES	NO
Constitution (Chronic fever, weight loss/gain, fatigue)	____	____
Cardiovascular (Chest pain, irregular heart beat, ***high blood pressure***)	____	____
Ears, Nose, Mouth, Throat (Hearing loss, sinus, sore throat)	____	____
Respiratory (Shortness of breath, asthma, emphysema)	____	____
Gastrointestinal (Heartburn, vomiting, abdominal pain)	____	____
Genitourinary (Kidney, bladder/urinary, genitals)	____	____
Musculoskeletal (Arthritis, muscle pain, joint pain)	____	____
Integumentary (Skin problems, rashes, excessive dryness)	____	____
Neurological (Headaches, migraines, seizures, numbness)	____	____
Psychiatric (Depression, anxiety)	____	____
Endocrine (***DIABETES***, thyroid, problems with other glands)	____	____
Hematologic/Lymphatic (Anemia, bleeding problems)	____	____
Allergic/Immunologic (Allergies)	____	____

Other conditions _____
If you answered YES to any of the above, please EXPLAIN treatments and/or medications used.
_____
_____

Past/Present Ocular History

	YES	NO		YES	NO
Glaucoma	____	____	Loss of vision	____	____
Cataracts	____	____	Tired eyes	____	____
Macular Degeneration	____	____	Eye pain or soreness	____	____
Eye injuries	____	____	Double vision	____	____
Retinal Disease	____	____	Excessive tearing	____	____
Blindness	____	____	Itchy eyes	____	____
Strabismus (Lazy eye)	____	____	Burning, red eyes	____	____
Amblyopia	____	____	Flashes	____	____
Dry Eyes	____	____	Floaters	____	____
Refractive (Blur)	____	____	Glare/Light Sensitivity	____	____

Other conditions/concerns _____

(Please complete the back side also)

Family History/Relationship

Please identify any parents, grandparents, siblings and/or children for the following conditions

	YES	NO	If YES, please explain relationship to you
Glaucoma	____	____	_____
Cataracts	____	____	_____
Macular Degeneration	____	____	_____
Eye Injuries	____	____	_____
Retinal Disease	____	____	_____
Blindness	____	____	_____
Strabismus (Lazy eye)	____	____	_____
Amblyopia	____	____	_____
Diabetes	____	____	_____
Cancer	____	____	_____
Heart Disease	____	____	_____
Arthritis	____	____	_____
High Blood Pressure	____	____	_____
Kidney Disease	____	____	_____
Thyroid Disease	____	____	_____

Other conditions/relationship _____

Patient Medical History

1. Have you ever had any surgery, major injuries and/or been hospitalized? YES NO
If YES, please explain: _____
2. PLEASE list all MEDICATIONS you take including supplements, vitamins and over the the counter eye drops:_____
_____
_____
3. Do you have any DRUG or food allergies? YES NO If YES, please list: _____
_____
4. If you are a female, are you currently pregnant and/or nursing? YES NO

Social History

Do you smoke? If yes, how much? _____
Do you drink alcohol? If yes, how much? _____
Do you drive? YES NO If YES, do you have difficulty seeing when driving? YES NO
If YES, please explain _____
_____
Please circle the following items you would like to update today. ***Glasses*** - ***Contacts*** . Are you interested in refractive surgery? YES NO

If employed, how many hours per week do you work? _____
Do you use a computer at work? YES NO
On average, how many hours daily? _____
Is computer use continuous? YES NO
Please list sports/hobbies that you participate in regularly. _____
_____
_____

_____ _____ _____ _____
Patient/Guardian Signature **Date** **Doctor Signature** **Date**

I have reviewed the above information and it remains the same as my last exam. Any new information has been noted above, initialed and dated. _____Initials