

# Registration and Medical History Questionnaire for Arnold Eye Center

Print this form and complete both pages of this Registration and Health History form and bring it to the office on your exam date.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/20\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

## Medical History

Name of Medical Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### My Drug Allergies

Drug Name	Reaction

### My Medications

Medication Name	Dose mg	How Often	Medication Name	Dose mg	How Often

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

Circle any of the following that **you** have had:

crossed eyes	lazy eye	drooping eyelid	prominent eyes
glaucoma	retinal disease	cataracts	eye infections/ injury

Are you pregnant or nursing?     no     yes

Do you wear glasses?     no     yes    If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lenses?     no     yes    If yes, how old is your present pair of lenses? \_\_\_\_\_

Type of contact lenses:     Rigid     Soft     Extended Wear     Other \_\_\_\_\_

Are they comfortable?     no     yes

Have you had vision surgery?     no     yes    If yes, which? RK PRK LASIK INTACS Ortho-K other \_\_\_\_\_

## Family History

Please note any family history (**parents, grandparents, siblings, children**; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Macular Degeneration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Retinal Detachment/Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Blindness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cataract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Crossed Eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Kidney Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Lupus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other		<input type="radio"/>	<input type="radio"/>	_____

\* Please complete page two \*

## Social History

*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Yes, I would prefer to discuss my Social History information with my doctor.

- Do you drive?  no  yes If yes, any visual difficulties? \_\_\_\_\_
- Do you use tobacco products?  no  yes If yes, type/amount/how long: \_\_\_\_\_
- Do you drink alcohol?  no  yes If yes, type/amount/how long: \_\_\_\_\_
- Do you use illegal drugs?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

## Review of Systems Do you currently, or have you ever had any problems in the following areas:

	NO	YES	?		NO	YES	?
<b>CONSTITUTIONAL</b>				<b>EARS, NOSE, MOUTH, THROAT</b>			
Fever, Weight Loss/Gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Allergies/Hay Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>INTEGUMENTARY (Skin)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sinus Congestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>NEUROLOGICAL</b>				Runny Nose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Post-Nasal Drip	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chronic Cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dry Throat / Mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>EYES</b>				<b>RESPIRATORY</b>			
Loss of Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blurred Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chronic Bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Distorted Vision/Halos	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of Side Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>VASCULAR / CARDIOVASCULAR</b>			
Double Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dryness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mucous Discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Redness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Vascular Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sandy or Gritty Feeling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>GASTROINTESTINAL</b>			
Itching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Burning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Foreign Body Sensation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>GENITOURINARY</b>			
Excess Tearing/Watering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Genitals/Kidney/Bladder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Glare/Light Sensitivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>BONES / JOINTS / MUSCLES</b>			
Eye Pain or Soreness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic Infection of Eye or Lid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Joint Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sties or Chalazion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>LYMPHATIC / HEMATOLOGIC</b>			
Flashes / Floaters in Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tired Eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Bleeding Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>ENDOCRINE</b>				<b>ALLERGIC / IMMUNOLOGIC</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid/ Other Glands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<b>PSYCHIATRIC</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

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\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date