Blair Eye Associates

REGISTRATION FORM

Welcome to Blair Eye Associates. We appreciate the opportunity to care for your health and take care of your vision necessities. Please fill out this form to the best your ability. We will do everything necessary to take the best care of your health and vision as well as protect your health information. Thanks again for your trust in our services.

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:

❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Rev.

Marital status (Check applicable)
❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow

Is this your legal name? ❑ Yes ❑ No

Alternate Name(s):

Social Security #: Birth date: Age: Sex: ❑ M ❑ F

Street address: Address #2 City: State: ZIP Code: Home Phone:

Cell Phone: May we contact you on your cell phone? ❑ Yes ❑ No

Preferred Phone for Contact:
❑ Home ❑ Work ❑ Cell

Email: May we contact you at this email? (Appointment reminders, materials arrival, education purposes, etc…) ❑ Yes ❑ No

Language: ❑ English ❑ Spanish ❑ German ❑ French ❑ Japanese ❑ Chinese ❑ Other ❑ Declined

Race: ❑ White ❑ Hispanic or Latino ❑ American Indian or Alaska Native ❑ African American ❑ Asian ❑ Native Hawaiian or Pacific Islander ❑ Other ❑ Declined

Ethnicity: ❑ Caucasian ❑ Hispanic or Latino ❑ African-American ❑ Asian ❑ Not Hispanic/Latino ❑ Other ❑ Declined

EMPLOYMENT INFORMATION

Occupation: Employer and Address: Work Phone No: May we contact you at work? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of relative or local friend (if not living at same address): Relationship to patient: Home phone no.: Work phone no.:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Yellow Pages ❑ Family ❑ Friend ❑ Close to home/work ❑ Other

Other family members seen here:

OCULAR HISTORY

How long since your last eye exam? __ Yr(s)

Do you wear glasses? ❑ Yes ❑ No (Never) ❑ Lost or Broken (Not wearable)

Do you wear Contact Lenses? ❑ Yes ❑ No

If Yes – What Brand?

CL Solution

Past Ocular History

❑ Amblyopia (Lazy Eye) ❑ Aphakia (Surgery to remove a lens without replacement)	❑ Cataracts ❑ Diabetic Retinopathy ❑ Dry Eyes	❑ Glaucoma ❑ Graves Disease ❑ Herpes Simplex ❑ Herpes Zoster (Shingles)	❑ Histoplasmosis ❑ Iritis ❑ Keratoconus	❑ Macular Degeneration ❑ Optic Neuritis ❑ Retinal Detachment

Have you had any injuries to your eyes? ❑ Yes ❑ No If yes, please list and explain:

Have you had any type of eye surgery?

❑ LASIK/PRK ❑ Cataract ❑ Retinal Detachment ❑ Blepharoplasty (Eyelid) ❑ Glaucoma

❑ RK ❑ Strabismus ❑ Corneal Transplant ❑ Removal of Foreign Material (metal, etc…) ❑ Other _____

Date of Surgery(s) (if recalled):

PERSONAL (YOUR) MEDICAL HISTORY

Vitals and Measurements		**Constitutional** *(General Health)*	**Ear Nose Throat**	**Neurological** *(Brain/Nervous System)*
What is your height? ft	in	❑ **Negative/None** ❑ Fatigue ❑ Cancer ❑ Fever ❑ Excessive Weight Gain/Loss ❑ Excessive Thirst ❑ Loss of Appetite ❑ Other	❑ **Negative/None** ❑ Hearing Loss ❑ Sinusitis ❑ Dry Mouth ❑ Laryngitis ❑ Other	❑ **Negative/None** ❑ Multiple Sclerosis ❑ Epilepsy ❑ Cerebral Palsy ❑ Tumor ❑ Stroke/CVA ❑ Migraine ❑ Other
What is your weight? lbs				
Blood Sugar mg/dl				
A1c (3 Month Average) % (i.e. 6.2)				
Blood Pressure /				
Dominant Hand ❑ Right ❑ Left				

Psychological *(Mood & Behavior)*	**Cardiovascular** *(Heart & Vessels)*	**Respiratory** *(Breathing)*	**Gastrointestinal** *(Stomach & Digestion)*	**Genitourinary** *(Urinary/Bowels)*
❑ **Negative/None** ❑ Depression ❑ Attention Deficit ❑ Anxiety Disorder ❑ Bipolar Disorder ❑ Other	❑ **Negative/None** ❑ High Blood Pressure ❑ Stroke/CVA ❑ Heart Disease ❑ Vascular Disease ❑ Congestive Heart Failure ❑ Other	❑ **Negative/None** ❑ Asthma ❑ Bronchitis ❑ Emphysema ❑ Chronic Obstruction ❑ Sleep Apnea ❑ Other	❑ **Negative/None** ❑ Crohn's ❑ Colitis ❑ Ulcer ❑ Acid Reflux ❑ Celiac Disease ❑ General Indigestion ❑ Other	❑ **Negative/None** ❑ Kidney Disease ❑ Prostate Disease/Cancer ❑ STD ❑ Benign Prostatic Hypertrophy ❑ Pregnant ❑ Nursing ❑ Other

Musculoskeletal *(Bones/Joints/Ligaments)*	**Integumentary** *(Skin)*	**Endocrinology** *(Hormones & Chemicals)*	**Hematologic/Lymphatic** *(Blood & Fluids)*	**Allergy/Immunology** *(Auto-Immune)*
❑ **Negative/None** ❑ Arthritis ❑ Fibromyalgia ❑ Muscular Dystrophy ❑ Ankylosing Spondylitis ❑ Osteoporosis ❑ Gout ❑ Other	❑ **Negative/None** ❑ Eczema ❑ Rosacea ❑ Psoriasis ❑ Herpes Simplex/Cold Sores ❑ Herpes Zoster/Shingles ❑ Other	❑**Negative/None** ❑Type 1 Diabetes Mellitus ❑Type 2 Diabetes Mellitus ❑Thyroid Dysfunction ❑Hormonal Dysfunction ❑Other	❑**Negative/None** ❑ Anemia ❑ Large-Volume Blood Loss ❑ Ulcer ❑ High Cholesterol ❑ Other	❑ **Negative/None** ❑ Drug Allergies ❑ Environmental Allergies ❑ Rheumatoid Arthritis ❑ Lupus ❑ Sjogren's Syndrome ❑ Other

Who is your Medical Doctor/Specialist?	
Have you had any major surgeries? (i.e. hip, gallbladder, cancer removal, open heart, etc…)?	

MEDICATIONS/VITAMINS/SUPPLEMENTS/ OVER THE COUNTER

Name of Medication	Medical Condition	Dosage	Frequency

❑ **See Attached Sheet of Medication brought by Patient**

ALLERGIES

Medication Allergies ❑ Yes ❑ No

Allergy	Reaction

Environmental/Other Allergies ❑ Yes ❑ No

Allergy	Reaction

Do you have an allergy to Latex? ❑ Yes ❑ No

SOCIAL HISTORY

Do you drink or use alcohol?	❑ Yes	❑ No	If yes, please specify: ____drinks per day/week/month
Do you smoke or use chewing tobacco?	❑ Yes	❑ No	If yes, please specify: ____cigarettes/packs per day | ____dips/cans per day
Do you currently or have you used recreational drugs in the past?	❑ Yes	❑ No	If yes, please specify:

FAMILY (IMMEDIATE) MEDICAL HISTORY

****Family applies only to immediate family – i.e. Parents, siblings, grandparents and great-grandparents – Aunts and Uncles can apply if you would like.****

Past Family Medical History	Affected Family Members
❑ **Negative/None**	
❑ High Blood Pressure	
❑ Diabetes Mellitus	
❑ Cancer	
❑ Thyroid Dysfunction	
❑ Stroke/CVA	
❑ Multiple Sclerosis	
❑ Other	

Past Family Ocular History	Affected Family Members
❑ **Negative/None**	
❑ Cataracts	
❑ Diabetic Retinopathy	
❑ Glaucoma	
❑ Keratoconus	
❑ Macular Degeneration	
❑ Retinal Detachment	
❑ Other	

SIGNATURE AND ATTESTATION

The above information is true to the best of my knowledge. If applicable, I authorize my insurance benefits be paid directly to the Dr. Ryan G. Palmer and Blair Eye Associates. I understand that I am financially responsible for any balance. I also authorize Blair Eye Associates, L.L.C. or insurance company to release any information necessary or required to process my claims.

_____ _____

Patient/Guardian signature ***Date***