

**WELCOME TO GREENSPAN FAMILY EYECARE**

**REGISTRATION**

Date: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
Mr. \_\_\_\_\_ Mrs. \_\_\_\_\_ Miss \_\_\_\_\_ Ms. \_\_\_\_\_ Dr. \_\_\_\_\_  
Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Number: \_\_\_\_\_  
Work Number: \_\_\_\_\_  
Cell Number: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
If Student, Grade: \_\_\_\_\_  
Referred by: \_\_\_\_\_

**MEDICAL HISTORY**

Name of Family Physician: \_\_\_\_\_  
Date of last physical exam: \_\_\_\_\_  
Are you currently taking Medications? Yes \_\_\_ No \_\_\_  
If yes, please list (include over the counter medications and eye medications.)  

MEDICATION NAME	CONDITION BEING TREATED
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any allergies to medicine? Yes \_\_\_ No \_\_\_  
If yes, please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PATIENT EYE HISTORY**

Date of Last Exam: \_\_\_\_\_ By Whom: \_\_\_\_\_  
Do you wear Eyeglasses? Yes \_\_\_ No \_\_\_  
distance only \_\_\_\_\_ bifocals \_\_\_\_\_  
reading only \_\_\_\_\_ progressive \_\_\_\_\_  
Do you wear contact lenses? Yes \_\_\_ No \_\_\_  
soft \_\_\_ gas permeable \_\_\_ brand \_\_\_\_\_  
Do you sleep with your contact lenses? Yes \_\_\_ No \_\_\_  
How often do you change your contact lenses? \_\_\_\_\_

**THERE IS A FEE FOR EVALUATION OF YOUR CURRENT CONTACT LENSES.**

Have you ever been diagnosed or treated for any of the following:

___ Cataract	___ Glaucoma	___ Retinal Disease
___ Conjunctivitis	___ Iritis	___ Dry Eye
___ Corneal Abrasion	___ Eye Injuries	___ Eye Surgeries
___ Macular Degeneration	___ Double Vision	

Do you experience or have you ever experienced any of the following:

___ Blurred Vision	___ Flashes of Light	___ Burning
___ Floaters	___ Crossed eye/eye turn	___ Headaches
___ Double Vision	___ Itching	___ Dryness
___ Night Glare	___ Eye Pain	___ Redness
___ Eye Strain	___ Tearing	

What is the main reason for today's visit? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**REVIEW OF SYSTEMS** - Do you currently, or have you ever had any problems in the following areas:

<b>Vascular/Cardiovascular:</b> ___ Diabetes ___ High Blood Pressure ___ Vascular Disease ___ Cholesterol	<b>Respiratory:</b> ___ Asthma ___ Chronic Bronchitis ___ Emphysema
<b>Endocrine:</b> ___ Thyroid/Other Gland	<b>Bones/Joints/Muscles:</b> ___ Rheumatoid Arthritis ___ Muscle Pain ___ Joint Pain
<b>Neurological:</b> ___ Headaches ___ Migraines ___ Seizures	<b>Ear/Nose/Throat:</b> ___ Allergies ___ Sinus Problems ___ Dry Mouth
<b>Hematological:</b> ___ Anemia ___ Bleeding problems	<b>Gastrointestinal:</b> _____ _____
<b>Psychiatric:</b> _____ _____	<b>Integumentary (skin):</b> _____ _____

**FAMILY HISTORY:**

CONDITION	RELATION
___ High Blood Pressure	_____
___ Diabetes	_____
___ Heart Disease	_____
___ Cancer	_____
___ Thyroid Disease	_____
___ Glaucoma	_____
___ Cataracts	_____
___ Macula Degeneration	_____
___ Retinal Disease	_____
___ Blindness	_____