D. DOUGLAS FRIEND, O.D.
PATIENT REGISTRATION INFORMATION

Date:_____Patient's Name:_____
Parent's Name (if minor)_____Spouse:_____
Date of birth:_____Age:_____
Address:_____City:_____State:_____Zip:_____
Home phone: _____ Cell phone:_____Wk phone:_____
Patient's Occupation:_____Employer:_____
If student, grade in school_____
Vision Care Insurance Company: _____
Authorization to release information to insurance company (please initial) _____

STATEMENT OF EYE PROBLEMS

Main reason for today's exam:_____

Other problems:_____

EYE HISTORY

Approximate date of last eye exam:_____
Do you currently wear glasses? Y N If yes, when are they used?_____
Do you currently wear contacts? Y N If yes, when are they used?_____
Have you ever had any of the following? If yes, please describe.

Eye diseases:_____
Eye injuries:_____
Eye surgery:_____
Other eye problems:_____

GENERAL HEALTH AND FAMILY HISTORY

Have you or any of your blood relatives ever had any of the following conditions? If yes please mark the appropriate column.

CONDITION	YOURSELF	RELATIVE(relationship)
Glaucoma	_____	_____
Cataracts	_____	_____
Blindness	_____	_____
Turned/Lazy eye	_____	_____
Arthritis	_____	_____
Diabetes	_____	_____
High Blood Pressure	_____	_____
Heart Condition	_____	_____
Thyroid	_____	_____
Sinusitis	_____	_____
Other Conditions	_____	_____

MEDICATI0NS: (please list) _____

_____

ALLERGIES: (please list any allergies to medications, pollen, animals, foods, etc.)

_____

Do you work at a computer or video display terminal? Y N
What hobbies or sports do you enjoy?_____
Does the sun bother your eyes? Y N
Do you need extra eye protection at work or in a home workshop? Y N