

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.

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

MEDICATIONS: (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