Welcome to
Looking Out Vision, P.C.

Patient Registration Form

Legal Name: _____ DOB:_____/_____/_____

Preferred Name / Nickname: _____ Sex (for medical care):_____Race/Ethnicity:_____

Home Address:_____

Preferred Contact Number:_____(Home / Cell / Work) Do we have permission to send text messages?

Alternate Contact Number:_____(Home / Cell / Work) Yes / No

Email Address:_____

Emergency Contact/Guardian (relationship to you):_____Phone:_____

Occupation/Grade in School:_____Employer/School:_____

Patient/Guardian Signature:_____Today's Date: :_____/_____/_____

OCULAR HISTORY

Have you ever worn glasses? Yes, I currently wear glasses. I used to wear glasses. I've never worn glasses.

If you wear contact lenses, what type of lenses do you wear? Soft Rigid

Please indicate if you or any family members have any history of the following eye conditions:

Eye Condition	Self	Family Member (indicate relationship to you)
Cataracts		
Glaucoma		
Macular Degeneration		
Retinal Detachment/Disease		
Dry Eye		
Eye Turn/Lazy Eye/Amblyopia		
Other (please indicate what)		

Please list any history of eye surgeries or laser procedures and the approximate date (ie, cataract or LASIK):

_____

_____

Please list any history of eye injury or severe eye infection:

_____

Please list any eye drops, ocular medications, or eye vitamins/supplements that you use:

_____

_____

Do you smoke or use tobacco products? No / If yes, indicate amount per day:_____

Do you drink alcohol? No / Yes, socially / Yes, daily

Do you use marijuana? No / If yes, indicate how often:_____

General Medical History	Please check the box next to any condition you have or have had:	☐ All Normal / No Significant Medical History
Allergic/Immunologic ☐ Environmental Allergies ☐ Other	***Cardiovascular/Cardiac*** ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Other	***Constitutional*** ☐ Fever ☐ Weight Loss / Gain ☐ Other
Ears, Nose, Mouth, Throat ☐ Sinus Congestion ☐ Dry Throat / Mouth ☐ Other	***Endocrine*** ☐ Diabetes ☐ Thyroid Disease ☐ Chronic Fatigue ☐ Other	***Gastrointestinal*** ☐ Diarrhea / Constipation ☐ IBS / Crohn's Disease ☐ Ulcers ☐ Reflux ☐ Other
Genitourinary ☐ Kidney Disease ☐ Ovarian / Uterine Cancer ☐ Prostate Cancer ☐ Other	***Hematologic / Lymphatic*** ☐ Anemia ☐ Bleeding Problems ☐ Breast Cancer ☐ Other	***Integumentary (Skin)*** ☐ Cancer ☐ Rashes ☐ Easy Bruising ☐ Other
Musculoskeletal ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Muscle Pain ☐ Joint Pain ☐ Other	***Neurological*** ☐ Migraine Headaches ☐ Dizziness ☐ Seizures ☐ Stroke ☐ Other	***Psychiatric*** ☐ Anxiety ☐ Depression ☐ Memory Loss ☐ Other
Respiratory ☐ Asthma ☐ Sleep Apnea ☐ Emphysema ☐ COPD ☐ Other	Women, please indicate if you are pregnant or nursing (please circle): Pregnant, due date: _____ Nursing	**Please list any drug allergies:** ☐ **None**

Family Medical History	(please specify which family members, if any, have the following conditions)
Hypertension	Diabetes
High Cholesterol	Arthritis
Heart Disease	Cancer

Who is your Primary Physician?_____City:_____

Please list any medications you are currently taking (include oral contraceptives and over-the-counter medications):