

PATIENT REGISTRATION AND HEALTH HISTORY FORM
SIOUX FALLS FAMILY VISION

Patient's Name Date
Parent or Responsible Person's Name Age Birthdate
Mailing Address Home Tel. #
Work Tel. #
Occupation
Employer
If a student: Grade
School Name
Whom may we thank for referring you to us?

What is your reason for seeking vision care at this time?

WILL TODAY'S EXAMINATION BE PAID FOR BY: CIRCLE ONE:

Cash Check Insurance Credit Card HMO Medicare Medicaid Other
Name of Insurance Carrier?

Family Health History Patient's Health History Patient's Visual Symptoms
Allergies Allergies Distance vision blurred
Asthma Asthma Near vision blurred
Cancer Blackouts Discomfort at distant visual tasks
Diabetes Cancer (e.g. driving, movies)
Drug sensitivity Diabetes Discomfort at near visual tasks
Hay fever Drug sensitivity (e.g. reading, sewing)
Heart condition Hay Fever Light sensitivity
High blood pressure Heart condition Double vision
Migraine headaches Hepatitis Occasional vision changes
Skin conditions High blood pressure Temporary loss of vision
Thyroid condition HIV / Aids See flashing lights
Tuberculosis Migraine headaches See floaters or spots
Blindness Skin conditions Eye strain
Cataracts Thyroid condition Headaches
Glaucoma Tuberculosis Burning eyes
Lazy eye Blindness/Reduced Vision Red eyes
Poor color vision Cataracts Itching eyes
Retinal Disease Glaucoma Watering eyes
Turned Eye Poor color vision Dry eye
Retinal disease Twitching eyelid
Turned eye

(PLEASE COMPLETE THE BACK SIDE ALSO)

Explanation of health history, where necessary.

Do you consider your health? Good Fair Poor
Are you presently taking any medication or drugs? Yes No . If yes, what drugs are you taking?
Are you allergic to any medications? Yes No . If yes, which?

Have you ever had any serious eye disease, eye injury, or eye surgery? Yes No
If yes, please explain

When was your last eye examination?
What is your previous eye doctor's name?
When was your last visit to your physician?
What is your physician's name?
Do you wear contact lenses? Yes No . If yes, which type? hard soft
Additional Comments: