FAMILY EYE CARE
OF ELMWOOD PARK

NEW PATIENT REGISTRATION FORM

TODAY'S DATE: _____

PATIENT INFORMATION

LAST NAME MR MS MISS DR	FIRST NAME	MI	DATE OF BIRTH

STREET ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	EMAIL

EMPLOYER (OR SCHOOL)	OCCUPATION (OR GRADE)	HOBBIES/INTERESTS

HOW DID YOU HEAR ABOUT OUR OFFICE?	WHOM MAY WE THANK FOR REFERRING YOU?
☐ INSURANCE ☐ WEBSITE/INTERNET ☐ PHONE BOOK ☐ MAILING ☐ REFERRAL ☐ OTHER	

NAME OF PARENT/GUARDIAN (IF < 18)	HOME OR CELL PHONE	RELATION TO PATIENT

PRIMARY CARE DOCTOR	DATE OF LAST PHYSICAL	LAST EYE DOCTOR	LAST EYE EXAM

MEDICAL INSURANCE	POLICY HOLDER'S NAME	POLICY HOLDER'S D.O.B.	RELATION TO PATIENT

VISION DISCOUNT PLAN	POLICY HOLDER'S NAME	POLICY HOLDER'S D.O.B.	RELATION TO PATIENT

DO YOU CURRENTLY WEAR?	ARE YOU INTERESTED IN:
☐ GLASSES	☐ NEW GLASSES
☐ SUNGLASSES	☐ TRYING CONTACT LENSES
☐ CONTACT LENSES	☐ REFRACTIVE SURGERY (LASIK)
	☐ A NON-SURGICAL ALTERNATIVE TO GLASSES & CONTACTS

VISUAL FUNCTION: PLEASE CHECK ALL THAT APPLY TO YOU:

☐ WORK ON A COMPUTER AT LEAST 6 HRS/DAY	☐ EXPERIENCE GLARE WHILE DRIVING AT NIGHT
☐ EXPERIENCE EYESTRAIN AT THE COMPUTER	☐ CONTACT LENSES GET DRY AT LEAST ONCE PER DAY
☐ EYES ARE SENSITIVE TO SUNLIGHT	☐ CONTACT LENSES ARE NOT AS CLEAR AS DESIRED
☐ SPEND A LOT OF TIME OUTDOORS (GOLF, FISHING, ETC.)	☐ WOULD LIKE INFO ON THINNER/LIGHTER LENSES

HAVE YOU EVER HAD?

☐ CATARACT SURGERY ☐ RETINAL SURGERY

☐ LASIK SURGERY ☐ OTHER SURGERY

☐ EYE MUSCLE SURGERY

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

☐ BLURRED VISION	☐ DRYNESS	☐ FLOATERS	☐ SANDY/GRITTY FEELING
☐ BURNING	☐ EXCESSIVE TEARING	☐ GLARE	☐ SUDDEN LOSS OF VISION
☐ DOUBLE VISION	☐ EYE PAIN	☐ EYE/EYELID INFECTION	☐ LOSS OF SIDE VISION
☐ DROOPY EYELID	☐ FLASHES OF LIGHT	☐ ITCHING	☐ OTHER

VISION HISTORY:

	SELF	FAMILY
AMBLYOPIA/LAZY EYE	☐	☐
BLINDNESS	☐	☐
CATARACTS	☐	☐
COLOR BLINDNESS	☐	☐
CROSSED EYE	☐	☐
DIABETIC RETINOPATHY	☐	☐
GLAUCOMA	☐	☐
KERATOCONUS	☐	☐
MACULAR DEGENERATION	☐	☐
RETINAL DETACHMENT	☐	☐
EYE INJURY	☐	☐
OTHER EYE CONDITION	☐	☐

CURRENT MEDICATIONS:

ALLERGIES:

MEDICAL HISTORY:

	SELF	FAMILY
ALLERGIES	☐	☐
ARTHRITIS	☐	☐
CANCER	☐	☐
CARDIO (HEART, CAROTID)	☐	☐
CHOLESTEROL (HIGH)	☐	☐
DIABETES	☐	☐
FATIGUE	☐	☐
GASTRO (STOMACH/COLON)	☐	☐
GENITAL, KIDNEY, BLADDER	☐	☐
HEADACHE/MIGRAINE	☐	☐
HERPES SIMPLEX/ZOSTER	☐	☐
HIGH BLOOD PRESSURE	☐	☐
HIV/AIDS	☐	☐
AUTO-IMMUNE DISEASE	☐	☐
LUPUS	☐	☐
MUSCLE, JOINT, BONE	☐	☐
NEUROLOGICAL (M.S.)	☐	☐
NOSE, SINUS, THROAT	☐	☐
PSYCH (ANXIETY, DEPR.)	☐	☐
RESP (ASTHMA, COPD)	☐	☐
SKIN (ACNE, ECZEMA)	☐	☐
STROKE	☐	☐
SUDDEN WEIGHT CHANGE	☐	☐

SOCIAL HISTORY:

DO YOU SMOKE? Y N _____PACKS/DAY

DO YOU DRINK ALCOHOL Y N _____DRINKS/WEEK

ARE YOU PREGNANT? Y N

ARE YOU NURSING? Y N

Doctor's Signature: _____ Date: _____