



## Demographics

### PATIENT REGISTRATION FORM

Title	First	Last	MI	Suffix	Nickname
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address: <input type="text"/>					
<input type="text"/>					
City: <input type="text"/>			State/ZipCode: <input type="text"/> <input type="text"/>		
Home Phone: <input type="text"/>			Work Phone: <input type="text"/>		
Other Phone: <input type="text"/>			Emergency Contact #: <input type="text"/>		
SSN: <input type="text"/>			Email: <input type="text"/>		
Date of Birth: <input type="text"/>			Occupation: <input type="text"/>		
<i>mm/dd/yyyy</i>					
Sex: <input type="checkbox"/> Male			Employment Status: <input type="checkbox"/> Employed		
<input type="checkbox"/> Female			<input type="checkbox"/> Full-Time Student		
			<input type="checkbox"/> Part-Time Student		
Marital Status: <input type="text"/>			Employer/School Name: <input type="text"/>		
Primary Doctor: <input type="text"/>			Drivers License #: <input type="text"/>		

### Billing Information

Check if Billing Address is the Same:

Title	First	Last	MI	Suffix	Nickname
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address: <input type="text"/>					
<input type="text"/>					
City: <input type="text"/>			State/ZipCode: <input type="text"/> <input type="text"/>		
Home Phone: <input type="text"/>					
Work Phone: <input type="text"/>					

## PATIENT INFORMATION

Patient Name:

Preferred Name:

Preferred Day Phone:

Parent / Guardian:

Relationship to Patient

Preferred Day Phone:

Parent / Guardian:

Relationship to Patient:

Preferred Day Phone:

Please list all family members who are currently patients with Lifetime Eye Care:

Which Doctor referred you to our office?

Did someone else refer you to our office?

If not referred, how did you hear about Lifetime Eye Care?

Are you coming to our office:

as a New Patient?

returning as a Previous Patient?

Is this visit for:

an Emergency?

an on the job injury involving Worker's Compensation?

## Insurance

### PRIMARY VISION INSURANCE INFORMATION

Insurance Name:

Insurance ID:

Insurance Policy Group #:

Primary on Account  Not Primary on Account

#### Primary on Account

Name:

*Last, First MI*

Relationship to Insured:

Spouse

Child

Other

Sex:

Male

Female

Address:

City:

State:

Zip:

Phone Number:

Date of Birth:

*mm/dd/yyyy*

Employer/School:

## SECONDARY VISION INSURANCE INFORMATION

Insurance Name:

Insurance ID:

Insurance Policy Group #:

Primary on Account  Not Primary on Account

### Primary on Account

Name:

*Last, First MI*

Relationship to Insured:  Spouse  Child  Other

Sex:  Male  Female

Address:

City:  State:  Zip:

Phone Number:

Date of Birth:  *mm/dd/yyyy*

Employer/School:

## MEDICAL INSURANCE INFORMATION

Insurance Name:

Insurance ID:

Insurance Policy Group #:

Primary on Account  Not Primary on Account

### Primary on Account

Name:

*Last, First MI*

Relationship to Insured:  Spouse  Child  Other

Sex:  Male  Female

Address:

City:  State:  Zip:

Phone Number:

Date of Birth:  *mm/dd/yyyy*

Employer/School:

# Medical History

## EYE HEALTH HISTORY

When was your most recent Eye Examination?

Who was your previous Eye Doctor?

Who is your Primary Care General Physician?

Do you have any MEDICATION ALLERGIES?  No  Yes

If Yes, please list all Medications you are allergic to (including eye drops):

Please list all EYE MEDICATIONS you are currently using including over the counter non-prescription Eye medications and drops:

Please list all OTHER MEDICATIONS you are currently taking and the condition for which you are taking them:

*(including over the counter non-prescription supplements and medicines)*

Please list any Eye Injuries or Eye Surgeries you have had:

Have you been diagnosed with any of the following Eye Conditions? Please check all that apply:

**Blindness**

**Corneal Dystrophy**

**Thyroid Eye Disease**

**Cataract**

**Eye Cancer**

**Macular Degeneration**

**Implant Lens Right Eye**

**Glaucoma**

**Retinal Detachment**

**Implant Lens Left Eye**

**Hypertension Retinal Disease**

**Diabetic Retinal Disease**

**Dry Eye Syndrome**

**Amblyopia / Lazy Eye**

**Strabismus / Wandering Eye**

*If yes complete Section V  
DRY EYE HISTORY*

*If yes, complete Section IV  
STRABISMUS / AMBLYOPIA HISTORY*

*If yes, complete Section IV  
STRABISMUS / AMBLYOPIA HISTORY*

Other Eye Conditions?

Please check any of the following Eye Symptoms you currently experience. The more detailed History Sections and Checklists noted below will come later in this Medical History Form.

**Change in Distance Vision**

**Flashes of Light**

**Eye Pain**

**Change in Near Vision**

**Light Sensitivity**

**Dryness or Burning**

**Fluctuating Vision**

**New Spots or Floaters**

**Sandy or Gritty Feeling**

**Double Vision**

**Itching**

**Excess Tearing**

**Loss of Side Vision**

**Mucous Discharge or Crusted Lids**

*If YES above complete Section IV  
DRY EYE HISTORY*

**Eye Strain with Reading or Computer Work**

**Dizziness or Car Sickness**

*If yes complete Section III  
READING AND COMPUTER SYMPTOMS*

*If yes complete Section VI  
VISUAL MOTION SENSITIVITY*

Other Eye Symptoms?

## VISION HISTORY

What is your primary Vision Correction?

Have you ever worn Contact Lenses?

Are you interested in Contact Lenses?

What type of Contact Lenses are you currently wearing or have you worn in the past?

*(Soft, Gas Permeable, Daily Wear, Occasional Wear, Extended Wear, Toric, Bifocal, Monovision, CRT, Ortho-K)*

Are your contact lenses comfortable and working well for you?

Do you have additional glasses?

*(back up glasses, Reading glasses, Computer glasses, Sunglasses, Music glasses, etc.)*

What is your occupation?

How many hours per day do you work on the computer?

What type of work do you do with your eyes?

In what other visual activities do you participate such as arts & crafts, sewing, wood working, music, pool, cards, sports (which ones), etc.

Has patching ever been recommended?

Has Vision Therapy ever been recommended?

Completed?

Do you Drive?  No  Yes

Do you use Low Vision Devices for magnification?

Are you interested in Laser Vision Correction?

## CURRENT GENERAL HEALTH HISTORY

Do any of the following conditions apply to you?

No Yes

Allergy / Hay Fever

Asthma

Thyroid Disease

Cancer

Depression

Diabetes (Insulin dependent)

Diabetes (Non-insulin dependent)

Herpes Zoster

Whiplash

*Complete Section VI  
BRAIN INJURY HISTORY*

No Yes

Headaches

Migraines

Hepatitis

HIV

High Blood Pressure

Low Blood Pressure

High Cholesterol

Parkinson's Disease

Brain Injury

*Complete Section VI  
BRAIN INJURY HISTORY*

No Yes

Currently Pregnant

Rheumatoid Arthritis

Seizures

Sinus Problems

Skin Rashes

Multiple Sclerosis

Alzheimer's

Head Injury

*Complete Section VI  
BRAIN INJURY HISTORY*

Stroke

*Complete Section VI  
BRAIN INJURY HISTORY*

Please list any other Conditions:

*(such as Autism Spectrum Disorder, Down's Syndrome, ADD/ADHD, Hearing Impaired, Speech Impaired, Anxiety Disorder, Chronic Ear Infections, etc.)*

Do you use any of the following?

Alcohol:  No  Yes    Tobacco:  No  Yes    Recreational Drugs:  No  Yes

## FAMILY HISTORY

Is there a history of any of the following conditions in your immediate family? (Parents, Grandparents, Aunts, Uncles, Siblings)

- Diabetes       Rheumatoid Arthritis       Albinism       Retinal Detachment  
 Retinal Disease       High Blood Pressure       Glaucoma       Macular Degeneration  
 Amblyopia / Lazy Eye       Crossed or Wandering Eye

Other Family History of Eye Conditions:

## DETAILED INFORMATION

In the Detailed History Sections below, you will find additional questions which will help us to address your individual vision and eye health needs based on age, visual demands (reading & computer use), specific conditions (strabismus, dry eyes, brain injury, motion sensitivity) and sports performance.

Please **check the History Sections below** which apply to you and then complete those sections below. We have **highlighted** the sections you should check and fill out based on your previous answers. Please check any others you believe apply to you as well.

**CHILD EXAM:** Please check and complete History Sections I, II, III and any others which apply to your child.

**ADULT EXAM:** Please check and complete any of the following History Sections which apply to you.

- Section I PEDIATRIC HISTORY (for children 12 years of age and younger)**  
 **Section II SCHOOL RELATED HISTORY**  
 **Section III READING AND COMPUTER SYMPTOM CHECKLIST (for children and adults)**  
 **Section IV STRABISMUS / AMBLYOPIA HISTORY (for children and adults with Lazy Eye - an eye turn - crossed or wandering eye)**  
 **Section V DRY EYE HISTORY**  
 **Section VI BRAIN INJURY HISTORY (Stroke, Head Injury, Concussion, Whiplash, Motor Vehicle Accident, Bike Accident, etc.)**  
 **Section VII VISUAL MOTION SENSITIVITY CHECKLIST (Dizziness, Motion Sickness, Car Sickness, etc.)**  
 **Section VIII SPORTS VISION HISTORY (Professional athletes and weekend warriors)**

## SECTION I: PEDIATRIC HISTORY

*(for children 12 years of age and younger)*

Were there any birth complications?

- Premature     NICU     Forceps / Vacuum     Fetal Drug Exposure     Fetal Alcohol Exposure

Is your child  Adopted?  Foster Child?    Since what age?

Were there any developmental concerns or special circumstances which might have impacted development?

At what age did your child creep and crawl?       At what age did your child walk?

Describe any unusual motor development:

Which hand does your child use for: Eating       Throwing       Hammering       Writing

Which foot does your child use for: Hopping       Kicking       Toe drawing in the sand

How well is your child performing compared to others his or her same age?

Was early speech clear to others?

Is speech clear now?

Have any of the following evaluations been performed? If so, please bring a copy of the report to your child's examination

- Hearing**     **Auditory Processing**     **Speech and Language**     **Educational testing for an IEP**  
 **Motor**     **Psychological**     **Neurological**     **SOI**

## SECTION II: SCHOOL RELATED HISTORY

Current Grade  School

Age at entrance into: Preschool  Kindergarten  First Grade

Has attendance been regular?  Has any grade been repeated?  Which?

Describe any tutoring, special classes or IEP:

School work is:  **Above Average**     **Average**     **Below Average**     **Mixed**

Which subjects are easy for your child?

Which subjects are difficult for your child?

Is your child working harder than you think they should have to in order to do well?

Did your child have difficulty learning to read?  Is reading comfortable and efficient?  Does your child like to read?

Does your child prefer to be read to rather than reading on their own?  Does your child have a learning disability

## SECTION III: READING AND COMPUTER SYMPTOM CHECKLIST

*(for children and adults)*

Please check any of the following symptoms you have noticed when reading, doing close work or computer work:

- |   |  |
|---|--|
| <input type="checkbox"/> <b>Eyes feel tired</b>                             | <input type="checkbox"/> <b>Head too close to the paper while reading or writing</b>       |
| <input type="checkbox"/> <b>Eyes feel uncomfortable</b>                     | <input type="checkbox"/> <b>Difficulty tracking moving objects, balls, etc.</b>            |
| <input type="checkbox"/> <b>Headache</b>                                    | <input type="checkbox"/> <b>Writing is crooked or poorly spaced</b>                        |
| <input type="checkbox"/> <b>Feel sleepy</b>                                 | <input type="checkbox"/> <b>Misalignment of digits or columns of numbers</b>               |
| <input type="checkbox"/> <b>Lose concentration</b>                          | <input type="checkbox"/> <b>Errors copying from chalkboard, computer or book</b>           |
| <input type="checkbox"/> <b>Trouble remembering what was read</b>           | <input type="checkbox"/> <b>Avoids near work or reading</b>                                |
| <input type="checkbox"/> <b>Double vision</b>                               | <input type="checkbox"/> <b>Difficulty completing assignments in the time allotted</b>     |
| <input type="checkbox"/> <b>Words move, jump, swim or float on the page</b> | <input type="checkbox"/> <b>Reverses or forgets letters, numbers or words</b>              |
| <input type="checkbox"/> <b>Reads slowly</b>                                | <input type="checkbox"/> <b>Confuses similar looking words</b>                             |
| <input type="checkbox"/> <b>Experience a pulling feeling around eyes</b>    | <input type="checkbox"/> <b>Difficulty recognizing the same word in the next paragraph</b> |
| <input type="checkbox"/> <b>Words blur or come in and out of focus</b>      | <input type="checkbox"/> <b>Poor spelling</b>  |
| <input type="checkbox"/> <b>Loss of place, skips or re-reads words</b>      | <input type="checkbox"/> <b>Poor visual-motor coordination</b>                             |
| <input type="checkbox"/> <b>Need to re-read the same line of words</b>      | <input type="checkbox"/> <b>Confuses right and left</b>                                    |
| <input type="checkbox"/> <b>Tendency to close or cover one eye</b>          | <input type="checkbox"/> <b>Difficulty following a sequence of directions</b>              |

Head tilt or movement

Whispers when reading silently

Poor reading comprehension

Comprehension decreases over time

## SECTION IV: STRABISMUS / AMBLYOPIA HISTORY

*(for children and adults with a Lazy Eye - an eye turn - crossed or wandering eye)*

At what age was the eye turn first noticed?  Did the eye turn start suddenly or gradually?

Which direction does the eye turn (check all that apply)?  In  Out  Up  Down

Is the eye turn getting worse, better or no change?

Which eye turns? (Right, Left, Both)

When does the eye turn? (always, what % of the time, when tired, when ill, etc.)

Does the eye turn more when looking:

up close

in the distance

to the left

to the right

up

down

Do you ever notice one or both eyes shaking rapidly?

If patching treatment was prescribed, please describe at what age patching was started, how it was done, the eye patched, for how long, and an estimate of the results:

Has there been any surgery?  What is your estimate of the results of surgery?

Please describe any visual therapy, including duration of treatment, age at which it was started, and estimate of the results:

## SECTION V: DRY EYE HISTORY

Which of the following risk factors for Dry Eye apply to you?

Less than 7 hours of sleep per night in an average week

Routinely use a ceiling fan in your bedroom

Use a breathing device while sleeping

Drink less than 3 glasses of water per day

Eat less than 3 servings of fish per week

Do you currently take any of the following medications?

Antihistamines

Diuretics (Lasix)

Anti-depressants

Beta Blockers

Active Bladder Therapy

Hormone Replacement Therapy

Glaucoma drops

Allergy drops

Radiation Therapy

Accutane (even previously)

Have you ever had eye surgery (Lasik, PRK, Cataract surgery, other)?

Over the past week, which of the following eye symptoms have you experienced?

Burning

Redness

Itching

Eye ache

Glare

Dry mouth

Dryness

Grittiness

Tearing

Stinging

Light Sensitivity

Night driving problems

Decreased contact lens wearing time

Mattering on your eyelids when you wake up in the morning

- Eye lids swollen or red along the lash margins
- Burning in the morning
- Vision fluctuates from clear to blurry especially in the morning, after reading, watching TV, computer use, or driving
- Artificial tear drops help but do not last long enough

Do you take omega-3 supplements such as fish oil?

## SECTION VI: BRAIN INJURY HISTORY

*(Stroke, Head Injury, Concussion, Whiplash, Motor Vehicle Accident, Bike Accident, etc.)*

Date of the event (accident, illness, injury, stroke, etc.)

Briefly describe the injury (stroke, aneurysm, trauma, whiplash, concussion, toxic substance -- involved what part of your head, brain or eye, etc.)

Describe any previous brain injury and date:

What rehabilitation therapy have you received for this injury?

What are your most significant vision concerns at this time?

If you experience any of the symptoms below, please check if the symptom was present before the injury or only after the injury.

**Before    After**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Visual headaches   |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in or around eyes   |
| <input type="checkbox"/> | <input type="checkbox"/> | Decreased blink rate   |
| <input type="checkbox"/> | <input type="checkbox"/> | Distorted vision   |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or motion sickness                                     |
|                          |                          | <i>Complete Section VII VISUAL MOTION SENSITIVITY CHECKLIST</i>  |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty understanding what is seen                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty recognizing words                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty recognizing faces                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty finding objects when grouped together                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendency to stare  |
| <input type="checkbox"/> | <input type="checkbox"/> | Memory problems  |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty reading   |
|                          |                          | <i>Complete Section III READING / COMPUTER SYMPTOM CHECKLIST</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty focusing one or both eyes                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent squinting or excessive blinking                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendency to close one eye to see more clearly                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision appears unstable or shifts from eye to eye                |
| <input type="checkbox"/> | <input type="checkbox"/> | Unusual head tilt or head turn                                   |

- Difficulty judging depth
- Portions of a page or objects appear to be missing
- People or things suddenly appear unexpectedly from one side
- Looking to the side of objects to see them better
- Tunnel vision
- Difficulty concentrating on visual tasks
- Discomfort in crowded areas with a lot of background motion
- Difficulty maintaining eye contact

## SECTION VII: VISUAL MOTION SENSITIVITY CHECKLIST

*(Dizziness, Motion Sickness, Car Sickness, etc.)*

Please check any of the following symptoms which are significant for you:

- Nausea, headache or dizziness when reading in the car even on a STRAIGHT road (not a winding road)
- Nausea, headache or dizziness when sitting close to a movie screen or watching a train go by
- Hyper-sensitive to light (store lights seem too bright, tend to wear sunglasses even on cloudy days)
- Frequent, sometimes daily headache or "pressure" in your head
- Nausea, headache, dizziness or spacey feeling when shopping or moving through crowds of people
- Unusual fear of heights
- Lose your place easily when reading
- Flickering lights bother you (light through the trees when you are riding in a car)

## SECTION VIII: SPORTS VISION HISTORY

*(Professional athletes and weekend warriors)*

Do you wear your prescription while playing your sport (glasses or contact lenses)?

Do you ever experience blur or double vision?  Under what conditions / at what distance / during your sport?

How is your game? How would you like to improve? Can you present specific examples?

How would you describe the consistency of your game? Does your performance deteriorate as the game goes on?  
Are there big differences in your game from day to day? Is there a difference in your performance from day to night?  
Or a difference during a tournament?

Do you feel your vision interferes with your game? If so, can you describe specific examples?

How is your ability to keep your eye on the ball? (Or other moving target / object) Please give an example

Is there a fluctuation in your vision when looking from one spot to another or when you are moving?

How would you describe your performance in critical situations under stress?

How do you feel vision is important in your sport?

Do you use visualization / imagery techniques? If yes, please describe. Would you like to further develop this skill?

Have you ever suffered a head injury, been hit in the head, incurred a concussion or whiplash?