Eyes in Disguise Optometry
Michelle C Blas, OD

Patient Registration Form

Patient Information

Full Name: ____________________________________ **Date of Birth:** _____________________

Address: ______________________________________ **Social Security #:** __________________

______________________________________ **Home Phone #:** ___________________

Email Address: ________________________________ **Cell Phone #:** _____________________

Medical Doctor: _______________________________ **Last Eye Exam:** ___________________

Emergency Contact: ____

Patient Communications: How do you prefer to receive information regarding appointments and services at Eyes in Disguise Optometry? (Circle all the apply) Email Text Phone

Patient Portal: Are you interested in participating in our online patient portal to have access to your health information at Eyes in Disguise Optometry? (Circle all that apply) Yes, tell me more No

Ocular History

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your current pair of glasses?_______________

Do you wear contact lenses? ☐ Yes ☐ No If yes what type? ☐ Rigid ☐ Soft ☐Toric ☐Multifocal

Contact Lens Brand: ___________________

Have you had ocular surgery? __________ If yes, Date: ________________ Type:______________________

What other services would you like to be evaluated for? ____

Are you having any visual difficulties? If yes please explain: _______________________________________

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Have you ever been diagnosed with any of the following?

☐ Cataract ☐ Age-related macular degeneration ☐ Glaucoma ☐ Diabetes ☐ Diabetic Retinopathy
☐ Dry Eye ☐ Eye infection ☐ Floaters and/or flashes of light ☐ Eye Inflammation or Allergy
☐ Iritis or Uveitis ☐Retina Defects or degenerations ☐ Crossed Eyes ☐ Lazy Eye/Amblyopia

Are you having any of the following eye concerns?
☐ Redness ☐ Burning ☐ Itching ☐ Tearing ☐ Discharge ☐ Blurred Vision ☐ Eyestrain
☐ Eye Pain ☐ Sensitivity to Lights ☐ Headache ☐ Poor Night Vision ☐ Night Glare
☐ Double Vision ☐ Total Loss of Vision ☐ Styes or Chalazion ☐ Mucous Discharge

Medical History

List any medications you are currently taking (include oral contraceptives, aspirin, and over the counter medications): ____

____

Are you allergic to any medications? ☐ No ☐ Yes If yes, which ones: ______________________

Are you currently pregnant or nursing? ____

Review of Systems

Please check the box beside any problem you currently have or have had in the past.

Constitution ☐ All Normal

☐ Cancer ☐ Fatigue Syndrome

☐ Developmental Disabilities

☐ Weight Loss/Gain

☐ Fever ☐ Other:___________

Psychiatric ☐ All Normal

☐ Depression ☐ ADD/ADHD

☐ Anxiety ☐ Bipolar

☐ Other: ___________

Cardiovascular ☐ All Normal

☐ Hypertension ☐ Heart Disease

☐ Vascular Disease ☐ Heart Failure

☐ Other:________

Gastrointestinal ☐ All Normal

☐ Chron's ☐ Colitis

☐ Ulcer ☐ Acid Reflux

☐ Celiac ☐ Other: ___________

Integumentary ☐ All Normal

☐ Eczema ☐ Rosacea

☐ Psoriasis ☐ Herpes Simplex

☐ Herpes Zoster ☐ Other___________

Hemotologic ☐ All Normal

☐ Anemia ☐ Ulcer

☐ Hypocholesteremia

Musculoskeletal ☐ All Normal

☐ Joint Pain ☐ Joint Swelling

☐ Muscle Pain ☐ Back Pain

ENT ☐ All Normal

☐ Hearing Loss ☐ Sinusitis

☐ Dry Mouth ☐ Laryngitis

☐ Other:______________

Neurological ☐ All Normal

☐ Multiple Sclerosis ☐ Epilepsy

☐ Cerebral Palsy ☐ Tumor

☐ Stroke/CVA ☐ Autism Spectrum

Respiratory ☐ All Normal

☐ Asthma ☐ Bronchitis

☐ Emphysema ☐ Chron. Obstruction

☐ Sleep Apnea ☐ Other:__________

Genitourinary ☐ All Normal

☐ Kidney Disease ☐ Prostate Cancer

☐ STD ☐ Other: __________

☐ Ovarian/Uterine Cancer

Endocrine ☐ All Normal

☐ Type 1 Diabetes ☐ Type 2 Diabetes

☐ Thyroid Dysfunction ☐ Other: _________

☐ Hormonal Dysfunction

Allergy/Immuno ☐ All Normal

☐ Environmental Allergies/ Hay Fever

☐ Rheumatoid Arthritis ☐ Lupus

Have you had any major injuries, illnesses, hospitalizations and or surgeries that we should know about? If yes, please explain: ____

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Family History

Please note any family history for the following conditions:

Cancer	□ Mother	□ Father	□ Sister	□Brother	□Other: _______________
Type 1 Diabetes	□ Mother	□ Father	□ Sister	□Brother	□Other: _______________
Type 2 Diabetes	□ Mother	□ Father	□ Sister	□Brother	□Other: _______________
Hypertension	□ Mother	□ Father	□ Sister	□Brother	□Other: _______________
Hyperthyroidism	□ Mother	□ Father	□ Sister	□Brother	□Other: _______________
Hypothyroidism	□ Mother	□ Father	□ Sister	□Brother	□Other: _______________
Cataract	□ Mother	□ Father	□ Sister	□Brother	□Other: _______________
Macular Generation	□ Mother	□ Father	□ Sister	□Brother	□Other: _______________
Glaucoma	□ Mother	□ Father	□ Sister	□Brother	□Other: _______________
Blindness	□ Mother	□ Father	□ Sister	□Brother	□Other: _______________
Cross Eyed	□ Mother	□ Father	□ Sister	□Brother	□Other: _______________
Lupus	□ Mother	□ Father	□ Sister	□Brother	□Other: _______________
Arthritis	□ Mother	□ Father	□ Sister	□Brother	□Other: _______________

Please describe any other family medical history that may be relevant: ______________________________

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Social History

This information is kept strictly confidential; however, you may discuss this with your doctor directly if you prefer.

Do you currently use tobacco products? □ No □ Yes If yes, type/how long: ____________________

Do you drink alcohol? □ No □ Yes If yes, type/amount: ______________________

Do you use illegal drugs □ No □ Yes If yes, type/amount: ______________________

Signature: ___________________________________ Date:____________________________