Forgues Eyecare & Associates

Please bring this form to your appointment
or you may email it to
WorcAdmin@ForguesEyecare.com

PATIENT REGISTRATION and HISTORY FORM

First, MI, Last, Name:

Date of Birth:

Social Security Number:

Street address:

City, State, Zip:

Cell Phone: Home Phone:

Email:

Gender: ☐ Male Female ☐

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Occupation/Employer:

Language:

Race, Ethnicity:

Emergency Contact Name: Phone:

Guarantor Name (if person to bill other than patient):

INSURANCE INFORMATION

Vision Discount Plan: ID#:

Medical Insurance: ID#:

Primary Care Physician: Phone:

REASON FOR TODAY'S VISIT?

If you DO NOT wear contact lenses, do you want to wear contact lenses? ☐ **Yes** ☐ **No**

For contact lens prescriptions: Per FDA regulations contact lens prescriptions are valid for one year. A contact lens evaluation is always a separate fee from your comprehensive eye examination; they include separate tests to measure the curvature of your eye, fit of the lens, and health of the eye. Contact lens fees may vary according to the complexity of the contact lens fit, or refit, and the type of lens used. If you have any questions regarding these fees, please ask a staff member or the doctor before your exam.

PATIENT HISTORY

OCULAR INFORMATION

Past Eye History: ☐ None ☐ Cataracts ☐ Glaucoma ☐ Keratoconus ☐ Other: ☐ Strabismus ☐ Amblyopia/Lazy Eye ☐ Double Vision ☐ Herpes Simplex/Zoster ☐ Trauma/Foreign Body/Scar ☐ Retinal Tear/Detach

Past Ocular Surgery: ☐ None ☐ Refractive Surgery ☐ Cataract ☐ Muscle ☐ Retinal Surgery ☐ Corneal Transplant ☐ Other:

Glasses History: ☐ None ☐ Near Only ☐ Distance Only ☐ Other/Type: ☐ Progressive ☐ Bifocal

Contact Lens History: ☐ None ☐ Soft Daily ☐ Soft Toric ☐ Soft Overnight ☐ RGP ☐ Hard PMMA

☐ Difficulty with contact lenses? ☐ Yes ☐ No

Last Used: _____

Comments:

MEDICAL INFORMATION

Allergies	☐ Yes	☐ No	To what?
Medication Allergy	☐ Yes	☐ No	To what?
Diabetes	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
Headaches	☐ Yes	☐ No	
Arthritis	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Elevated Cholesterol	☐ Yes	☐ No	
Healing Problem/Keloid	☐ Yes	☐ No	
HIV	☐ Yes	☐ No	
Pregnant / Nursing	☐ Yes	☐ No	
Any Operations / Surgeries?	☐ Yes	☐ No	If so, for what?

Do you have any issues with these systems?

Gastrointestinal	☐ Yes	☐ No	Musculoskeletal	☐ Yes	☐ No
Ears/Nose/Throat	☐ Yes	☐ No	Integumentary (skin)	☐ Yes	☐ No
Cardiovascular	☐ Yes	☐ No	Mental	☐ Yes	☐ No
Respiratory	☐ Yes	☐ No	Endocrine (glands)	☐ Yes	☐ No
Nervous	☐ Yes	☐ No	Blood/Lymph	☐ Yes	☐ No
Genitourinary	☐ Yes	☐ No	Allergic/Immunologic	☐ Yes	☐ No

Do you:

Smoke	☐ Yes	☐ No
Alcohol	☐ Yes	☐ No
Other substance	☐ Yes	☐ No

Family History:

Diabetes	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Macular Degen	☐ Yes	☐ No

Other Eye conditions:

Medications: ☐ None

Date of last eye health exam:

Date of last physical exam:

Occupation: