Patient Registration and History Questionnaire

NewVue Optometry

Please updated at each visit and complete both sides

Date:

Patient Name: ______ Guarantor (Primary Insured): ______

Address: ______ City: ______ Zip code: ______

Email: ______ Home Tel # ______

Occupation: ______ Cell Tel # ______

DOB: ______ Age: ______ Sex: ☐ F ☐ M Social Security # ______

Ethnicity: ☐ African American ☐ Asian ☐ Hispanic ☐ Caucasian ☐ Others:

Communication Preference: ☐ Phone ☐ Email ☐ Mail

Preferred Language: ______ Referred by: ______

Do you work on a computer? **Y N** #Hrs./Day:

Activities/Special Visual Demands:

Do you wear eyeglasses? Y N

If Yes, for DISTANCE NEAR BOTH

How old are the eyeglasses?

Do you wear contact lenses? Y N

If NO, are you interested in contact lenses Y N

If YES, what type of contact lenses are you wearing?

Soft-or-Gas Permeable (Hard)

Daily-or-Extended Disposable-or-standard

Astigmatism-or- Spherical Distance-or-Monovision

If YES:

Full time wear Occasional wear

Bifocal/Monovision Astigmatic

Color Contacts Sports

How old are your contact lenses?

What solution do you use?

Have you had refractive surgery? Y N

If No, are you interested in the procedure? Y N

Have you had any eye surgery? Y N

Please explain. ______

______

______

Insurance and Payment Authorization

Insurance Company: ______

ID # ______

I request that payment of authorized insurance benefits be made on my behalf to NewVue Optometry. I authorize the release of information necessary to process claims. I permit my signature to be kept on file for future visits and insurance filings.

I understand and agree that regardless of my insurance benefits I (or my guarantor) am responsible to pay for the balance on my account for all professional services and materials provided.

______

Patient or Parent's Signature **Date**

Consent for Dilation

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the doctor to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for the doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

_____ I consent to have the procedure.

_____ I DO NOT consent and decline the procedure.

______

Patient or Parent's Signature **Date**

Please complete backside →

Name of Previous Eye Doctor: Tel #: Date of Last Eye Exam

Name of Physician: Tel #: Date of Last Medical Exam

Purpose of Today's Visit:

FAMILY HEALTH HISTORY

Please check all that apply and state which relative ☐ **NO for all areas**

	Y	Relative		Y	Relative
Arthritis			Blindness		
Cancer			Cataracts		
Diabetes			Glaucoma		
Heart Disease			Lazy/Turned Eye		
High Blood Pressure			Macular Degeneration		
Thyroid			Retinal Detachment		

Other:

Please list all current medication

PATIENT HEALTH HISTORY: REVIEW OF SYSTEMS

Do you currently have problems in the following areas: ☐ **NO for all areas**

Constitutional	Y	?
Fever		
Weight loss/gain		
Cardiovascular		
Diabetes		
Hypertension		
Vascular Disease		
Heart Condition		
Gastrointestinal		
Diarrhea		
Constipation		
Genitourinary		
Kidney		
Bladder		
Genitals		
Neurological		
Headaches		
Migraines		
Seizures		
Respiratory		
Asthma		
Emphysema		
Chronic Bronchitis		
Hematological/Lymphatic		
Anemia		
Bleeding Problems		
Bones/Joints/Muscles		
Rheumatoid Arthritis		
Muscle Pain		
Joint Pain		
Ear, Nose, Mouth, Throat		
Allergies		
Hay Fever		
Sinus Congestion		
Other		

	Y	?
Allergic/Immunological		
Psychiatric		
Integumentary (Skin)		
Endocrine		
Thyroid/other glands		
Eyes		
Blurred vision at distance		
Blurred vision at near		
Burning		
Chronic infection of eye or lid		
Distorted Vision/Haloes		
Double Vision		
Dryness		
Excess Tearing/Watering		
Eye Exercises/Vision Therapy		
Eye pain or Soreness		
Flashes of light		
Floaters/Spots in vision		
Foreign body sensation		
Glare/light sensitivity		
History of patching an eye		
Itching		
Mucous Discharge		
Previous Eye Surgery		
Redness		
Sandy or Gritty feeling		
Sties or Chalazions		
Temporary Loss of Vision		
Tired Eyes		

Have you had any recent surgeries? Y N

If YES, please explain

Are you allergic to any drug?

☐ No Known Allergy Or

Please list drug allergies:

SOCIAL HISTORY

Do you Drive? Y N

If Yes, do you have any visual difficulty when driving Y N

If YES, please explain:

Ages 13 years or Older:

Do you use

Cigarettes/ Tobacco? Y N

If YES, how many packs?

If No, Quit Date

Do you use Alcohol? Y N

Do you use any other substance/recreation drugs? Y N

Have you been exposed to or infected with any infectious or immune disease? Y N

If YES, please explain: