Optometry Registration Form

Name(Last)_____(First)_____(M.I.)_____ (Preferred name)_____

Date and location of last eye exam:_____ Date of Birth:_____

How did you hear about Fenway Health's Optometry Department:_____

State any problems you are having with your eyes or vision:

_____

_____

Do you currently or did you ever wear Glasses?_____ Contact Lenses?_____

Have you had any interest in wearing contact lenses or Laser Vision Correction?_____

Do you use Tobacco?___ Alcohol?___, Recreational drugs?____

Occupation:_____ Hobbies. Special visual needs?_____

MEDICAL INFORMATION:

Please list ALL Medications: □None List:_____

_____

_____

Allergies/Adverse reactions to medications: □None

List:_____

_____

_____

Do You Have Any of The Following (please circle all that apply):

General: weight loss or gain, fatigue, weakness, fever or chills, other_____

Ears, nose, throat: decreased hearing, ringing, nasal congestion, sinus problems, other_____

Cardiovascular: chest pain, high blood pressure, heart problems, high cholesterol, other_____

Respiratory: cough, shortness of breath, wheezing, asthma, tuberculosis, other_____

Gastrointestinal: swallowing difficulties, nausea, vomiting, diarrhea, other_____

Genito-urinary: blood in urine, frequent urination, sexually transmitted disease, other_____

Musculoskeletal: muscle or joint pain or swelling, muscle weakness, arthritis, other_____

Neurological: headache, seizures, numbness, tingling, dizziness, other_____

Psychiatric: depression, stress, nervousness, poor concentration, other_____

Endocrine: thyroid problems, diabetes, cold intolerance, excessive thirst, other_____

Immune: HIV, lupus, other_____

EYE HISTORY:

Current Eye Symptoms: (Check All that Apply) ☐Blurred vision ☐ Flashes/floaters ☐Double vision ☐Headaches ☐Loss of vision ☐ Other:_____

Have you or any member of your family ever had any of the following eye disorders?:

	YOU	FAMILY
☐Cataracts	_____	_____
☐Glaucoma	_____	_____
☐Macular Degeneration	_____	_____
☐Herpes Simplex/Zoster	_____	_____
☐Amblyopia/Lazy Eye	_____	_____
☐Dry Eye	_____	_____
☐Eye Injuries	_____	_____
☐Eye Surgery	_____	_____

☐Other:_____