

**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 \_\_\_\_\_

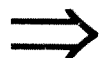
Cardiovascular: chest pain, high blood pressure, heart problems, high cholesterol, other \_\_\_\_\_

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?:

	<u>YOU</u>	<u>FAMILY</u>
<input type="checkbox"/> Cataracts	_____	_____
<input type="checkbox"/> Glaucoma	_____	_____
<input type="checkbox"/> Macular Degeneration	_____	_____
<input type="checkbox"/> Herpes Simplex/Zoster	_____	_____
<input type="checkbox"/> Amblyopia/Lazy Eye	_____	_____
<input type="checkbox"/> Dry Eye	_____	_____
<input type="checkbox"/> Eye Injuries	_____	_____
<input type="checkbox"/> Eye Surgery	_____	_____
<input type="checkbox"/> Other: _____		

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