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__________________________

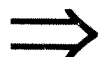
Cardiovascular: chest pain, high blood pressure, heart problems, high cholesterol, other_________________________

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:_____________