Medical Record Number
(for office use only)

Optometry Registration Form

Name(Last)_____(First)_____(M.I.)_____ (Name used)_____

Date & 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? Are you interested in wearing contact lenses? _____

Have you ever had Laser Vision Correction? _____ Would you like to discuss 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:_____

_____

_____

Are you pregnant or nursing? _____

Review of Systems:

Do you have any of the following? Please circle and/or list all that apply.

General: weight loss or gain, fatigue, weakness, fever or chills, history of concussion, other _____

Ears/Nose/Throat: decreased hearing, ringing, nasal congestion, sinus problems, other _____

Respiratory: cough, shortness of breath, wheezing, asthma, tuberculosis, other _____

Gastrointestinal: swallowing difficulty, nausea, vomiting, diarrhea, other _____

Genito-urinary: blood in urine, frequent urination, sexually transmitted infection, other _____

Musculoskeletal: muscle or joint pain or swelling, muscle weakness, arthritis, other _____

Continue on opposite side ------->

Cardiovascular: chest pain, high blood pressure, heart problems, high cholesterol, 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, rheumatoid arthritis, other _____

Eye History:

Current Eye Symptoms: (check all that apply) ☐ **Blurred vision** ☐ **Flashes/floaters** ☐ **Double vision** ☐ **Headaches** ☐ **Loss of vision**

☐ **Redness** ☐ **Pain** ☐ **Discharge** ☐ **Dry eyes** **Other:**_____

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

	YOU	**FAMILY (Please list relation)**
☐ **Cataracts**	_____	_____
☐ **Glaucoma**	_____	_____
☐ **Macular Degeneration**	_____	_____
☐ **Herpes Simplex/Zoster**	_____	_____
☐ **Amblyopia/Lazy Eye**	_____	_____
☐ **Dry Eye**	_____	_____
☐ **Eye Injuries**	_____	_____
☐ **Eye Surgery**	_____	_____

☐ **Other:** _____

Reviewed by Doctor	**Reviewed and updated by patient**
Sign: _____ Date: _____	✱Initial: _____ Date: _____
Sign: _____ Date: _____	Initial: _____ Date: _____
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