Essential Eye Care, PLLC

Patient Registration

Welcome to *Essential Eye Care, PLLC*. Thank you for choosing us for your eye care needs.

Please take a moment to complete the following information.

Patient Information:

Last Name _____First Name _____ MI _____

Preferred Name _____ M/F ____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone# _____ Cell Phone# _____ Work#_____

Email Address _____

Reason for visit today _____

When was your last eye exam _____

Do you currently wear glasses? Y/N _____

Do you currently wear or have you ever worn contacts? Y/N _____ If No, would you like to try them today Y/N ____

Brand of contacts _____

Are you concerned about any eyelid lumps or bumps? Y/N _____

Patient Eye History- Please indicate if you have ever been diagnosed with any of the following:

Please check all that apply

	Glaucoma		Surgery		Lazy Eye/ Patching
	Glaucoma Suspect		Inflammatory Disease		Retinal Degeneration/ Hole/Tear
	Cataract		Injury		Dry Eye
	Age Related Macular Degeneration		Lasik/ Refractive Surgery		Other-

Primary Care Physician Name/ Clinic _____

List any medications, including eye drops, you are currently taking _____

_____

_____

Are you allergic to any medications? Y/N ____ If yes, please list _____

_____

Are you Pregnant? Y/N_____ or Nursing? Y/N _____

Social History

Do you consume alcohol? Y/N _____ If yes, how often _____

Do you use tobacco products? Y/N ____ If yes, method of tobacco and how often _____

Family Health/ Eye History

Please check all that apply to immediate family members and indicate relationship to patient (**Mother, Father, Brother, Sister, Daughter, Son**)

	Cancer- M F B S D S		Macular Degeneration - M F B S D S
	Diabetes - M F B S D S		Cataract - M F B S D S
	High Blood Pressure - M F B S D S		Glaucoma - M F B S D S
	Thyroid - M F B S D S		Lazy Eye - M F B S D S
	Other-		Other-

Patient Review of Systems

Please check the box if you have ever had or are currently experiencing any to the following conditions

Constitution		Developmental Disabilities		**Gastrointestinal**		Crohn's Disease
		Cancer				Colitis
		Fatigue Syndrome				Acid Reflux
Ear/ Nose/ Throat		Hearing Loss				Celiac Disease
		Sinusitis		**Genitourinary**		Kidney Disease
		Dry Mouth				Chronic Obstruction
		Laryngitis				Other
Neurological		Multiple Sclerosis		**Musculoskeletal**		Osteoarthritis
		Epilepsy				Fibromyalgia
		Cerebral Palsy				Ankylosing Spondylitis
		Tumor				Osteoporosis
		Stroke/CVA				Gout
		Migraine		**Integumentary**		Eczema
Psychiatric		Depression				Rosacea
		Attention Deficit				Cold Sores
		Anxiety Disorder				Shingles
		Bipolar Disorder		**Endocrine**		Type 2 Diabetes
		Autism Spectrum Disorder				Type 1 Diabetes
Cardiovascular		High Blood Pressure (Hypertension)				Thyroid Dysfunction
		Heart Disease		**Hematologic/ Lymphatic**		Anemia
		Vascular Disease				High Cholesterol
		Congestive Heart Disease		**Allergic/ Immune**		Environmental Allergies
Respiratory		Asthma				Rheumatoid Arthritis
		Bronchitis				Lupus
		Emphysema				Sjogren's Syndrome
		Chronic Obstuction		**Other- Please List**		
		Sleep Apnea				