Patient Registration and Health History Form – Existing Patient

DATE _____

Patient's Name _____ Age _____ Date of Birth _____

Street Address _____ City _____ State_____ Zip_____

Preferred Phone _____ (cell/home/work) Secondary Number _____ (cell/home/work)

Email address _____

Primary Care Physician: _____

Occupation: _____

*** Reason for today's visit?** _____

Patient's Visual Symptoms (Check with an (x) if you are currently experiencing)

☐ None, periodic examination ☐ Distance vision blurred ☐ Near vision blurred ☐ Red eyes
☐ Temporary loss of vision ☐ See flashing lights ☐ See floaters or spots ☐ Itching eyes
☐ Watering eyes ☐ Light sensitivity ☐ Double vision ☐ Dry eyes
☐ Twitching eyelid ☐ Eye strain ☐ Other (list)_____

Patient's Medical Health History (Check with an (x) if you have, or have ever had, any of the following)

☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Thyroid Condition ☐ Autoimmune Disease
☐ Allergies ☐ Anxiety Disorder ☐ Depression ☐ Heart Attack/Stroke ☐ Respiratory Condition
☐ Headaches ☐ Pregnant (currently) ☐ Hard of Hearing ☐ Cancer (If yes, type:_____)
☐ Other (list)_____

Family History of Eye/Health Disease

☐ Glaucoma ☐ Cataracts ☐ Macular Degeneration ☐ Diabetes ☐ High Blood Pressure
☐ Thyroid Condition ☐ Cancer ☐ Other(list) _____

Any changes to medications?

Alcohol Use? Tobacco Use? If yes: Packs per day: ____ How many years?: ____

Please read the following concerning our policy information and sign if you understand and will abide:
I hereby give my consent to the physicians and other clinical personnel of Poudre Valley Eyecare for the evaluation and treatment of myself or my dependent on an ongoing basis. I understand that I have the right to revoke this consent in writing at any time.

I grant permission for Poudre Valley Eyecare doctors to exchange information from my records with other healthcare providers.

Signature of Responsible Person _____ Date _____

Print Name _____ Relationship to Patient _____