Account #________________________

Today's Date: ______________________

Patient Registration Information

First Name: __________________________ M.I. ________ Last Name: ______________________________

SSN: _______ - _______ - _______ Sex: ❒M ❒F Date of Birth: ____________________________

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Legally Separated

EMPLOYER / SCHOOL INFORMATION

Employment Status: ❒ Employed ❒ Retired ❒ Disabled ❒ Student ❒ Self-employed ❒ Unemployed

Employer Name: ____

Employer Address: ____

HOME INFORMATION

Street Address: ____

City, State, Zip: ____

E-mail: _______________________________________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: __________________

REFERRAL INFORMATION

Referring Physician: ____________________________________ Phone: __________________________________

Primary Care Medical Doctor: ____________________________ Phone: __________________________________

INSURANCE INFORMATION

#1) Insurance Carrier: _________________________________ Group# :__________________________________

ID#: ______________________________ Relationship to Subscriber: ❒ Self ❒ Spouse ❒ Dependent ❒ Other: ____

If subscriber is someone other than the patient, please complete the following:

SSN: _________________________ First Name: __________________ M.I. _______ Last Name: _________________

Sex: ❒ M ❒F Date of Birth: _______________

#2) Insurance Carrier: _________________________________ Group# :__________________________________

ID#: ______________________________ Relationship to Subscriber: ❒ Self ❒ Spouse ❒ Dependent ❒ Other: ____

If subscriber is someone other than the patient, please complete the following:

SSN: _________________________ First Name: __________________ M.I. _______ Last Name: _________________

Sex: ❒ M ❒F Date of Birth: _______________

EMERGENCY CONTACT INFORMATION (other than home number)

Name: ___________________________________ Relationship to Patient: __________________ Sex: ❒ M ❒F

Phone: ____________________ Work Phone: ___________________ Cell Phone: ____________________

Name: ___________________________________ Relationship to Patient: __________________ Sex: ❒ M ❒F

Phone: ____________________ Work Phone: ___________________ Cell Phone: ____________________

Account #______________________

Today's Date: ____________________

CINCINANTI EYE INSTITUTE
PATIENT HISTORY FORM

Patient Name: ______________________________ **SS#:** ____________________ **Date of Birth:** ____________

Primary Care Physician:______________________________ **Optometrist:** ______________________________

Cardiologist: ________________________ **Medication Allergies & Reactions:** ______________________________

Pharmacy: ______________________ **Pharmacy Phone #** (_______)___________________________

History of Latex Allergy? ☐ YES ☐ NO **Height**:____________ **Weight**: ____________

Have you or any family members had an anesthesia reaction? ☐ YES ☐ NO

REVIEW OF SYSTEMS - Do you currently have any of the following problems?

System	Yes/No	Date Diagnosed	Condition/Current Treatment/Surgery
Eye disease, eye injury, eye surgery	☐ Yes ☐ No		
Constitutional (fever, weight loss, other)	☐ Yes ☐ No		
Ears (reduced hearing or hearing loss)	☐ Yes ☐ No		
Nose/Mouth/Throat (sinus problems, sore throat)	☐ Yes ☐ No		
Cardiovascular (heart,vascular) hypertension	☐ Yes ☐ No		
Pacemaker/Defibrillator	☐ Yes ☐ No		
Respiratory (breathing problems, lungs, cough)	☐ Yes ☐ No		
Gastrointestinal (heartburn, diarrhea, vomiting, GERD, acid reflux)	☐ Yes ☐ No		
Neurological (numbness, weakness, stroke, headaches, paralysis,)	☐ Yes ☐ No		
Females – Pregnant? / Nursing?	☐ Yes ☐ No		
Genitourinary (male or female organ problems, urinary problems, kidneys)	☐ Yes ☐ No		
Dialysis	☐ Yes ☐ No		
Dermatologic (skin rashes, excessive dryness)	☐ Yes ☐ No		
Musculoskeletal (muscle or joint problems)	☐ Yes ☐ No		
Rheumatoid Arthritis	☐ Yes ☐ No		
Diabetes/Thyroid	☐ Yes ☐ No		
Allergic/Immunologic	☐ Yes ☐ No		
Psychiatric (depression)	☐ Yes ☐ No		
Hematologic (bleeding tendency, anemia)	☐ Yes ☐ No		
Cancer (Type):	☐ Yes ☐ No		

FAMILY HISTORY:

☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Cataracts
☐ Yes ☐ No Retinal disease
☐ Yes ☐ No Other eye problems ______________________________

SOCIAL HISTORY:

Marital Status: ☐ Married ☐ Single ☐ Widowed
Currently Employed: ☐ Yes ☐ No
If yes, occupation: ______________________________
Use of Tobacco/Alcohol/Drugs: ☐ Yes ☐ No
Comments:______________________________

Please list all individuals you authorize to receive information about your care:

Individual	Relationship	Phone

Current Prescribed/Over-The-Counter Medications:

Name of Prescription/Medication	Taken for what condition	Dosage	Frequency

Have you ever taken any of the following medications? If Yes, please check box

☐ **Cardura** ☐ **Finasteride** ☐ **Hytrin** ☐ **Uroxatral** ☐ **Flomax** ☐ **Proscar**

History of any major illnesses, injuries or surgeries:

Procedure	Reason	When?

VISUAL FUNCTION QUESTIONS

Please check Yes or No if you are experiencing any difficulty with the following:

	Yes	No	Comments
Reading small print			
Reading newspaper or book			
Recognizing people when close			
Seeing steps, stairs, or curbs			
Difficulty driving on bright sunny days			
Difficulty driving at night			
Reading traffic signs, street signs			
Doing fine handiwork			
Writing checks, completing forms			
Playing games (i.e. bingo, cards)			
Taking part in sports (i.e. golf, tennis)			
Cooking/Hobbies			
Watching TV			
Bothered by glare/halos			
If yes, please describe			
Are you satisfied with your current vision?			

Patient's Signature:____________________ Date:____________

Physician's Signature:____________________ Date:____________

Reviewed/Updated Date: ____________ Interval Changes ☐ Yes ☐ No MD Signature: ____________