CHILDREN'S EYE CARE OF CONNECTICUT

ADULT PATIENT REGISTRATION

Patient Name (First / Middle Initial / Last):

_____

Patient Date of Birth (MM/DD/YY):

_____

Gender Assigned at Birth (circle one):

Female Male Prefer not to say

Date of Last Eye Exam (MM/DD/YY):

_____

Gender Identity (circle one)

Female Male Non-binary

Preferred Phone Number:

(_____)_____

Would you prefer (mark one or all):

Calls Text Messages Emails

Preferred Email Address:

_____

Mailing Address:

_____

City: _____ **State:** _____ **Zip Code:** _____

Primary Care Physician/ Referring Doctor - Name and Phone Number (if known):

_____

How did you hear about us?

_____

REASON FOR VISIT:

_____

MEDICAL HISTORY

Date of Last Eye Exam (MM/DD/YY): _____

EYE HISTORY: Has the patient ever been treated for:

☐	Cataracts	☐	Iritis/Uveitis
☐	Glaucoma	☐	Retinopathy (diabetes/high blood pressure)
☐	Amblyopia (lazy eye)	☐	Macular hole
☐	Strabismus (crossed eye)	☐	Blepharitis/Eyelid inflammation
☐	Dry eye	☐	Nearsightedness
☐	Macular degeneration	☐	Farsightedness
☐	Floaters	☐	Astigmatism
☐	Retinal tear	☐	Double vision
☐	Retinal detachment	☐	Eye allergies
☐	Eye injury _____	☐	Other _____

LIST ANY <u>EYE MEDICATIONS</u>:

_____

_____

LIST ANY <u>EYE SURGERIES/LASERS</u> (indicated which eye/year):

_____

_____

MEDICAL HISTORY (please check the box for any current or past treatment the patient has undergone):

☐	Asthma	☐	Hepatitis Type ____	☐	Heart Murmur	☐	Arthritis
☐	Bronchitis	☐	Liver Disease	☐	High Cholesterol	☐	Back/Neck Problems
☐	Emphysema	☐	Diabetes Type ____	☐	Ulcers	☐	Autoimmune Disease
☐	COPD	☐	Congestive Heart Failure	☐	Thyroid Problems	☐	Kidney/Urinary Problem
☐	Sleep Apnea	☐	High Blood Pressure	☐	Anemia	☐	Herpes
☐	ENT Problems	☐	Heart Disease	☐	Bleeding Disorders	☐	Skin Conditions
☐	Hard of Hearing	☐	Heart Attack	☐	HIV	☐	Seasonal Allergies
☐	Sinus Problems	☐	Stroke	☐	GI Problems	☐	Anxiety/Depression
☐	Headaches	☐	Pacemaker	☐	GYN Problems	☐	Other Psych Disorder

☐	Seizures	☐	Palpitations	☐	Prostate Problems	☐	Cancer _____
☐	Other Illnesses/injuries:						

SURGICAL HISTORY (please list all prior surgeries and the date [year]):

_____

_____

KNOWN ALLERGIES: Does the Patient have allergies to any medication (circle one)? YES NO

If yes, please explain _____

MEDICATIONS (please list all medications the patient is currently taking, including vitamins & supplements):

_____ _____ _____

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY (please circle all that apply):

Does the patient drink alcohol? YES NO Drinks per week? _____

Does the patient smoke? YES NO Packs per Day _____ Years _____

Previous smoker? YES NO How many years since the patient quit?_____

Any recreational drug use? YES NO What type?_____

FAMLY HISTORY (please select any family conditions and list relationship to patient i.e. mother, father, etc):

☐	High Blood Pressure _____	☐	Glaucoma_____
☐	Diabetes _____	☐	Macular Degeneration _____
☐	Cancer _____	☐	Cataracts _____
☐	Heart Disease _____	☐	Lazy Eye / Crossed Eye _____
☐	Retinal Detachment _____	☐	Other _____

Does the patient or any family have problems with anesthesia? YES NO

_____

IS THE PATIENT EXPERIENCING ANY OF THE FOLLOWING <u>EYE SYMPTOMS</u>? Circle one, if yes, please explain:

Does the patient wear glasses or contacts? YES NO _____

Does the patient have blurred vision? YES NO _____

Does the patient have difficulty driving? YES NO _____

Does the patient have trouble with night vision? YES NO _____

Glare/light sensitivity? YES NO _____

Dryness? YES NO _____

Tearing? YES NO _____

Itching/allergies? YES NO _____

Mucous discharge? YES NO _____

Redness? YES NO _____

Foreign body sensation? YES NO _____

Infection eye or lid? YES NO _____

Eye pain / soreness? YES NO _____

Double vision? YES NO _____

Loss of central or peripheral (side) vision? YES NO _____

Floaters/flashes of light? YES NO _____

Crossed eye? YES NO _____

Drooping eyelid? YES NO _____

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW?