Stonewall eye care

Patient Registration

Name: _____ Date of Birth: _____ Age: _____

Street Address: _____ City/State: _____ Zip : _____

Social Security # _____ Sex M/F: _____ Race: _____

Email: _____

Home Phone: _____ Cell Phone: _____ Work Number: _____

Married/Single/Divorced _____ Name Of Employer: _____

Occupation: _____ Medical Dr/PCP : _____ Last Exam: _____

Last Eye Exam Doctor: _____

Eye History

(Please circle any that apply to you)

Glaucoma	Loss of Vision	Blurred Vision	Foreign Body Sensation
Diabetic Retinopathy	Mucous Discharge	Double Vision	Sandy or Gritty Feeling
Color Blindness	Drooping Eyelid	Glare/Light Sensitivity	Dryness
Retinal Detachment	Crossed Eyes	Blindness	Tired Eyes
Amblyopia/Lazy Eye	Itching	Distorted Vision(Halos)	Burning
Eye Infections	Floaters or Spots	Headaches	Redness
Cataracts	Eye Pain/Soreness	Fluctuating Vision	Excess Watering
Macular Degeneration	Any Other: _____		

General Health Conditions

(please circle any that apply to you)

Muscles,Bones,Joints	Weight Loss/Gain	Post-Nasal Drip	Skin
Ears,Nose,Throat	Neurological	Chronic Cough	Stroke
Allergies	Respiratory	Gastrointestinal	Dry Throat/Mouth
Lupus	Endocrine	Anemia	Genitals/Kidney/Bladder
Blood/Lymph	AIDS/HIV	Cancer	Cardiovascular
Heart Disease	Rheumatoid	Arthritis	Emphysema
Joint Pain	Bleeding Problems	Thyroid Disease	High Blood Pressure
Pregnant/Nursing	Alcoholic Beverages	Smoke Cigarettes	Diabetes
Fever	If Circled any please Explain: _____		

_____

Please List any medication (Prescriptions/Over the counter) vitamins, and supplements that you are taking:_____

Drug Allergies: _____

Family/Ocular History

(Circle any that apply to Immediate family and indicate Relationship to you)

Arthritis_____ Macular Degeneration _____
Heart Disease _____ Diabetes _____
Cancer _____ Lupus _____
Retinal Detachment _____Kidney Disease _____
Hypertension _____ Stroke _____
Cataracts_____ Crossed Eye/Lazy Eye _____
Thyroid Disease _____ Glaucoma _____
Blindness _____ Color Blindness _____
Other (Explain) _____

Acknowledgment and Receipt of Privacy Practices

Stonewall Eye Care consultation practice is required by US federal law to maintain our patient's privacy and provide them with access to the notice of our legal duties and privacy and provide them with access to the notice of our legal duties and privacy practices with respect to protected health information (PHI). Your signature below hereby acknowledges that you have reviewed our HIPPA Notice of Privacy Practices document and understand that you may obtain a copy for your records upon request.

Print Name: _____

Signature: _____

Today's Date:_____