BEACON
eye care

New Patient Registration **Today's Date:**

Name Last First Middle Initial		
Date of Birth Month Day Year / /	**Gender** □ Male □ Female	**Social Security** (last four)
Race: □ White □ African American □ Asian/Pac.Island □ Decline	**Ethnicity:** □ Hispanic □ Non-Hispanic □ Decline	**Preferred Language:** □ English □ Other:
Local Address City State ZIP		
Billing Address (if different from above) City State ZIP		
Home Phone ( ) -	**Cell Phone** ( ) -	**Preferred Communication:** □ Home □ Cell □ Work □ Email □ Postal
Employer Occupation		**Work Phone** ( ) -
Email Address @		
Emergency Contact: Name Phone Number Relationship		
Parent/Guardian: (if under 18) Name Phone Number Relationship		
How did you learn about Beacon Eye Care?		

Please turn this page over to complete medical history

rev 09/2016

Your General Health	Your General Health	Family Health History	Ocular symptoms
Do you have a prior history of or currently suffer from...		Has anyone in your family suffered from...	Are you experiencing...
Skin □ Rosacea □ Melanoma **Lymphatic/Hematologic** □ Anemia □ Bleeding disorder **Immunologic** □ HIV/AIDS □ Sarcoidosis □ Lupus **Neurological** □ Multiple Sclerosis □ Parkinson's □ Stroke □ Headaches/Migraines □ Seizures **Ear, Nose, Throat** □ Allergies/Hayfever □ Sinus Congestion □ Dry Mouth □ Hearing Loss **Other** □ Cancer: _____	**Endocrine** □ Diabetes □ Hyper / Hypo Thyroid **Cardiovascular** □ High Blood Pressure □ Vascular Disease □ High Cholesterol **Respiratory** □ Asthma □ COPD/Emphysema □ Apnea **Psychiatric** □ Depression/Anxiety **Musculoskeletal** □ Rheumatoid Arthritis □ Muscle/Joint Pain □ Fibromyalgia **Gastrointestinal** □ Inflammatory Bowel Disease **Other**_____	□ Diabetes □ Heart Disease □ Glaucoma □ Macular Degeneration □ Cataract □ Blindness □ Crossed/Lazy Eyes □ Retinal Detachment □ Unknown □ Adopted **Ladies**: Are you pregnant Or nursing? Yes □ No □ **Social History** Do you... □ Drive □ Smoke □ Former Smoker Quit: _____ □ Consume Alcohol □ Use recreational drugs	□ Blacking out of Vision □ Blurred Vision □ Dryness □ Sandy/Gritty Feeling □ Redness □ Burning □ Itching □ Tearing/Watering □ Eye Pain or Soreness □ Mucous Discharge □ Stye or Chalazion □ Glare or Halos □ Light Sensitivity □ Flashes □ Floaters □ Double Vision □ Other:

Ocular History	Visual Needs	Medical History
Have you had…	Do you enjoy any of the following...	Who is your primary care physician? Date of last PCP visit:
□ Dry Eyes □ Glaucoma □ Cataract □ Macular Degeneration □ Retinal Detachment □ Blindness □ Iritis/Uveitis □ Lazy Eye □ Eye injury □ Eye surgery:_____ □ Other (please explain)	□ Crafts/Sewing □ Computer □ Reading □ Gardening □ Golfing □ Music □ Fishing □ Skiing □ Shooting □ Contact Sports	Medications: (if you have a list, we will be happy to photocopy it)
Options Do any of the following appeal to you...		Medication allergies:
□ Thinner/Lightweight Lenses □ No-line Bifocals □ Scratch Resistant Coating □ Safety Glasses	□ Sport Goggles □ Lenses that darken □ Anti-Glare Treatment □ Sunglasses □ Computer Glasses □ Laser Vision Correction	Do you currently wear glasses? □ Yes □ No Do you currently wear contact lenses? □ Yes □ No If no, are you interested in contact lenses? □Yes □No **Please bring your contact lens prescription information with you to your exam**