Richland County Health Department
Wellness Partners
2000 Hampton Street, Suite 3145
Columbia, SC 29204
Phone: 803.888.1692/ Fax: 803.888.1691

EYE CLINIC PATIENT REGISTRATION & HISTORY FORM

Today's Date: _____ / _____ / _____

Name: _____

Address: _____

City/State/Zip Code: _____

Primary Phone: _____

County: ❍ Richland ❍ Fairfield

Birth Date: _____ / _____ / _____ Age: _____

Sex: ❍ Male ❍ Female

Race/Ethnicity: ❍ African American/Black ❍ Caucasian/White ❍ Hispanic/Latino ❍ Other: _____

Date of most recent Eye Exam: _____

Do you have a medical doctor? ❍ No ❍ Yes

Name of Medical Doctor: _____

Doctor Phone: _____

Date of most recent Medical Exam: _____

MEDICAL HISTORY

Do you have any allergies to medication? ❍ No ❍ Yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications): _____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Have you ever had:

Crossed eyes ❍ No ❍ Yes Lazy eyes ❍ No ❍ Yes

Drooping eyelid ❍ No ❍ Yes Prominent eyes ❍ No ❍ Yes

Glaucoma ❍ No ❍ Yes Retinal Disease ❍ No ❍ Yes

Cataracts ❍ No ❍ Yes Eye infection ❍ No ❍ Yes

Eye injury ❍ No ❍ Yes

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?

❍ Eau Claire Cooperative Health Center
❍ Richland County DHEC
❍ United Way of the Midlands
❍ Palmetto Health
❍ Free Medical Clinic
❍ Other: _____

Are you pregnant and/or nursing? ❍ No ❍ Yes

Do you wear glasses? ❍ No ❍ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ❍ No ❍ Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❍ Rigid ❍ Soft ❍ Extended Wear ❍ Other

Are they comfortable? ❍ No ❍ Yes

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children – living or deceased) for the following conditions:

Disease/Condition	No	Yes	Unsure
Blindness	❍	❍	❍
Cataracts	❍	❍	❍
Crossed Eyes	❍	❍	❍
Glaucoma	❍	❍	❍
Macular Degeneration	❍	❍	❍
Retinal Detachment/Disease	❍	❍	❍
Arthritis	❍	❍	❍

Disease/Condition	No	Yes	Unsure
Cancer	❍	❍	❍
Diabetes	❍	❍	❍
Heart Disease	❍	❍	❍
High Blood Pressure	❍	❍	❍
Kidney Disease	❍	❍	❍

Lupus	❍	❍	❍	Thyroid Disease	❍	❍	❍

SOCIAL HISTORY

Do you drive? ❍ No ❍ Yes If yes, do you have visual difficulty when driving? ❍ No ❍ Yes

Do you use tobacco products? ❍ No ❍ Yes

Do you drink alcohol? ❍ No ❍ Yes

Do you use illegal drugs? ❍ No ❍ Yes

MEDICAL HISTORY

Do you currently, or have you ever had any problems in the following areas:

System	No	Yes	Unsure	System	No	Yes	Unsure
Constitutional	❍	❍	❍	**Ears, Nose, Mouth, Throat**	❍	❍	❍
Fever, Weight Loss/Gain	❍	❍	❍	Allergies/Hay Fever	❍	❍	❍
Integumentary (Skin)	❍	❍	❍	Sinus Congestion	❍	❍	❍
Neurological	❍	❍	❍	Runny Nose	❍	❍	❍
Headaches	❍	❍	❍	Post-Nasal Drip	❍	❍	❍
Migraines	❍	❍	❍	Chronic Cough	❍	❍	❍
Seizures	❍	❍	❍	Dry Throat/Mouth	❍	❍	❍
Eyes	❍	❍	❍	**Respiratory**	❍	❍	❍
Loss of Vision	❍	❍	❍	Asthma	❍	❍	❍
Blurred Vision	❍	❍	❍	Chronic Bronchitis	❍	❍	❍
Distorted Vision/Halos	❍	❍	❍	Emphysema	❍	❍	❍
Loss of Side Vision	❍	❍	❍	**Vascular/Cardiovascular**	❍	❍	❍
Double Vision	❍	❍	❍	Diabetes	❍	❍	❍
Dryness	❍	❍	❍	Heart Pain	❍	❍	❍
Mucous Discharge	❍	❍	❍	High Blood Pressure	❍	❍	❍
Redness	❍	❍	❍	Vascular Disease	❍	❍	❍
Sandy or Gritty Feeling	❍	❍	❍	**Gastrointestinal**	❍	❍	❍
Itching	❍	❍	❍	Diarrhea	❍	❍	❍
Burning	❍	❍	❍	Constipation	❍	❍	❍
Excess Tearing/Watering	❍	❍	❍	**Genitourinary**	❍	❍	❍
Glare/Light Sensitivity	❍	❍	❍	Genitals/Kidney/Bladder	❍	❍	❍
Eye Pain or Soreness	❍	❍	❍	**Bones/Joints/Muscles**	❍	❍	❍
Chronic Infection of Eye or Lid	❍	❍	❍	Rheumatoid Arthritis	❍	❍	❍
Flashes/Floaters in Vision	❍	❍	❍	Muscle Pain	❍	❍	❍
Tired Eyes	❍	❍	❍	Joint Pain	❍	❍	❍
Endocrine	❍	❍	❍	**Lymphatic/Hematologic**	❍	❍	❍
Thyroid/Other Glands	❍	❍	❍	Anemia	❍	❍	❍
Psychiatric	❍	❍	❍	Bleeding Problems	❍	❍	❍

If you answered <u>YES</u> to any of the diseases/conditions above or you have a condition not listed, please explain: _____

_____

_____

I certify that under penalty of perjury that the information presented on this application is the truth as I best know.

_____ _____

Patient Signature *Date*