Busack Eye Center

PATIENT REGISTRATION FORM

Today's Date: _____

Patient Name:_____**Preferred Nickname:** _____
(Last) (First) (Middle)

Address: _____ **Day time/Cell Phone:** _____

City: _____ **Home Phone:** _____

State: _____ **Zip Code:** _____ **E-Mail Address:** _____

Gender: □ M □ F **Marital Status:** □ Single □ Married □ Divorced □ Widowed □ Separated

Birth Date: _____/_____/_____ **Social Security #:** _____/_____/_____ **Age:** _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese
□ Portuguese □ Russian □ Spanish □ Other _____

NEAREST RELATIVE/FRIEND

Name: _____

Relationship to Patient: _____**Telephone:** _____

Pharmacy: _____ **Location (Street, City, State)** _____

Primary Care Physician: _____

Referring Physician:_____

Optometrist: _____

Other Eye Specialist: _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Insurance Co: _____ **Subscriber ID #:** _____

Policy Holder: _____ **Group #:** _____

Relationship to Patient: _____ **Policy Holder Birth Date:** _____/_____/_____

Policy Holder Soc. Sec. #: ____/____/_____

SECONDARY INSURANCE:

Insurance Co: _____ **Subscriber ID #:** _____

Policy Holder: _____ **Group #:** _____

Relationship to Patient: _____ **Policy Holder Birth Date:** _____/_____/_____

Policy Holder Soc. Sec. #: ____/____/_____

******Contact lenses MUST be removed before seeing technician or physician ******

Today's Date: _____

Medical History

Patient Name : _____ **Date of Birth: _____**

Do you wear contact lenses? ☐YES ☐ NO If yes, last worn? _____

****Contact lenses MUST be removed before seeing technician or physician ****

History of Illnesses: (Please mark all that apply)

☐ No history of illnesses

☐ Anemia
☐ Arrhythmia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Cancer
☐ Chicken Pox
☐ Congestive Heart Failure
☐ Diabetes
☐ Eczema
☐ Fibromyalgia
☐ Headache
☐ Hearing Loss
Other _____

☐ Hepatitis A / B / C
☐ Herpes Simplex
☐ Herpes Zoster / Shingles
☐ High Blood Pressure (Hypertension)
☐ High Cholesterol
☐ Histoplasmosis
☐ HIV / AIDS
☐ Hypothyroidism
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Lung Disease

☐ Lupus
☐ Meningitis
☐ Migraine
☐ MRSA
☐ Polymyalgia
☐ Psychiatric Disorder
☐ Skin Cancer
☐ Stroke
☐ Syphilis
☐ Thyroid Disease
☐ Toxoplasmosis
☐ Wound Infection

General Surgeries / Operations: (Please list or attach list)

_____

_____

Past Eye History: (Please mark all that apply)

☐ Overall Healthy
☐ Amblyopia (Lazy eye)
☐ Aphakia
☐ Artery/Vein Occlusion
☐ Astigmatism
☐ Cataracts
☐ Cornea Problem
☐ Diabetic Retinopathy
☐ Dry Eyes
☐ Glaucoma
☐ Iritis
☐ Keratoconus
☐ Macular Degeneration
☐ Optic Neuritis
☐ Retinal Detachment

Other _____

Eye Surgeries: (Please mark all that apply)

☐ No prior ocular surgery
☐ Blepharoplasty (Eye Lids)
☐ Cataract Surgery
☐ Corneal Transplant
☐ Foreign Body Removal
☐ Laser for Glaucoma
☐ Laser after Cataract
☐ LASIK / PRK
☐ Macular Hole
☐ Punctal Plugs
☐ Retinal Laser
☐ RK
☐ Strabismus Surgery (for Crossed Eyes)
☐ Trabeculectomy (Glaucoma surgery)
☐ Vitrectomy

Plaquenil (Hydroxychloroquine) for auto immune disease

Surgeon _____ Date _____Which eye? ☐ Right / ☐ Left

Current Medications: (Please include name of medication, dosage, and frequency)

_____

_____

Patient Name: _____ Date of Birth: _____

Medication Allergies and reaction: No known allergies _____

_____

_____

Social History: (Please mark all that apply)

Smoking: ☐ current, everyday smoker ☐ current, some day smoker ☐ former smoker ☐ never smoked

Alcohol Use: ☐ Yes ☐ No If yes, how much and how often? _____

Recreational Drug Use: ☐ Yes ☐ No If yes, what and how often? _____

Vaccinations:

Pneumonia_____ YES NO

Coronavirus COVID–19____ YES NO

Shingles_____ YES NO

Family History: (M=Mother, F=Father, B=Brother, S=Sister, G=Grandparent)

☐ Diabetes	M	F	B	S	G
☐ Stroke	M	F	B	S	G
☐ Blindness	M	F	B	S	G
☐ Macular Degeneration	M	F	B	S	G
☐ Arthritis	M	F	B	S	G
☐ Cancer	M	F	B	S	G
☐ TB	M	F	B	S	G
☐ Cataracts	M	F	B	S	G

☐ Retinal Disease	M	F	B	S	G
☐ Lazy Eye	M	F	B	S	G
☐ Heart Disease	M	F	B	S	G
☐ Kidney Disease	M	F	B	S	G
☐ Glaucoma	M	F	B	S	G
☐ Hypertension	M	F	B	S	G
☐ Retinal Detachment	M	F	B	S	G

Other _____

Review of Systems: (Please mark all that apply TODAY)

Eyes
☐ Poor Vision
☐ Eye Pain
☐ Tearing
☐ Redness
☐ Loss of Vision

Constitution/Symptoms
☐ Fever
☐ Chills
☐ Weight Loss

ENT and Mouth
☐ Stuffy Nose
☐ Earache
☐ Dry Mouth

Gastrointestinal
☐ Upset Stomach
☐ Diarrhea
☐ Constipation

Genitourinary
☐ Urinary Urgency

Musculoskeletal
☐ Joint Swelling
☐ Stiffness
☐ Decrease Range of Motion

Psychiatric
☐ Anxiety
☐ Insomnia

Allergic/Immunologic
☐ Swelling
☐ Allergic Reaction
☐ Hives

☐ Artificial Joints, with in the last 2 years

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Patient's Name _____ **Today's Date** _____

Date of Birth _____

Pre-Cataract Surgery - Visual Functioning Index (VF-8R) Patient Questionnaire

Do you have difficulty, even with glasses with the following activities?

1. Reading small print such as labels on medicine bottles, a telephone book or food labels?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
2. Reading a newspaper or book?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
3. Seeing steps, stairs or curbs?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
4. Reading traffic signs, street signs or store signs?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
5. Doing fine handwork like sewing, knitting, crocheting or carpentry?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
6. Writing checks or filling out forms?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
7. Playing games such as bingo, dominos, card games or mahjong?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
8. Watching television?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	

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CATARACT/IOL EVALUATION

Patient's Name _____ **Age** _____ **Date** _____

CATARACT EFFECT AND VISION PROBLEMS (please check all that apply)

- o Glare Problem
- o Trouble seeing in bright sun light
- o Difficulty reading
- o Trouble driving at night
- o Blurred vision

Do you drive at night?

- o Seldom
- o Often
- o Do Not Drive

Do you have Diabetes? YES / NO

- o Insulin
- o Oral Medication

Do you take any Blood Thinner? (Circle response) Coumadin / Plavix / Aspirin / none

Treatment for Urinary Conditions: (Circle or list those taken currently **OR** in the past)

Flomax / Avodart / Tamsulosin HCL / Hytrin
Terazosin / Carcura / Doxzaosin
Uroxatral / Alfuzon / Sanofiaventis
Saw Palmetto (an Herbal Supplement)
_____
_____

Would you prefer to limit or reduce your use of glasses? YES / NO

Do you prefer to wear glasses to correct you vision? YES / NO

Are you willing to pay extra for a specialty lens or procedure, that is **NOT** covered by **ANY** insurance, to reduce your dependence on glasses? YES / NO

Work / Occupation _____Computer Work _____hours per day

Do you exercise or perform strenuous activity on a regular basis? YES / NO

If Yes, how often? _____

ACTIVITIES/HOBBIES (circle) Crafts Reading TV Sports Golf

_____ _____
Patient's signature Date

I authorize _____to be present during this visit.

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