GULFCOAST EYE CARE

New Patient Registration & Health History

Please complete this form before your visit so we can spend your appointment time on your eyes rather than paperwork. If a question doesn't apply to you, just leave it blank.

PATIENT INFORMATION

Last name | First name | MI

Date of birth | Today's date | Preferred name

Marital status | Social Security No. (optional) | Preferred language

Do you live:

☐ Alone ☐ With spouse/partner ☐ In a care facility ☐ Other

Home address

City | State | ZIP

Home phone | Cell phone | Work phone

Email | Occupation (or former occupation, if retired)

Primary care physician | Primary care physician phone

HOW DID YOU HEAR ABOUT US?

Select all that apply:

☐ Physician referral ☐ Health insurance ☐ Website ☐ Friend or family ☐ Other

Referral name / details

I'M INTERESTED IN LEARNING ABOUT (OPTIONAL)

Select any that apply:

☐ LASIK (laser vision correction) ☐ Dry eye / LipiFlow treatment ☐ Eyelid surgery

EMERGENCY CONTACT

Name | Relationship

Phone

DEMOGRAPHIC INFORMATION (OPTIONAL)

We're asked to collect this for federal health reporting. You may decline any item.

Race:

☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American ☐ Native Hawaiian / Pacific Islander

☐ White ☐ Decline to answer

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

MEDICAL HISTORY

Do you now have, or have you ever had, any of the following? Check Yes or No for each.

Diabetes	☐ Y ☐ N	Arthritis	☐ Y ☐ N	Bleeding abnormalities	☐ Y ☐ N
High blood pressure	☐ Y ☐ N	Asthma	☐ Y ☐ N	Lupus	☐ Y ☐ N
Heart attack or failure	☐ Y ☐ N	Emphysema	☐ Y ☐ N	Cold sores	☐ Y ☐ N
Irregular heartbeat	☐ Y ☐ N	Bronchitis	☐ Y ☐ N	Sinus problems	☐ Y ☐ N
Stroke	☐ Y ☐ N	Ulcer / diarrhea	☐ Y ☐ N	Hearing loss	☐ Y ☐ N
Cancer	☐ Y ☐ N	Depression / anxiety	☐ Y ☐ N	Unexplained weight loss	☐ Y ☐ N
Hay fever / allergies	☐ Y ☐ N	Kidney stones	☐ Y ☐ N		
Thyroid problem	☐ Y ☐ N	Kidney failure	☐ Y ☐ N		

If cancer, type:

Other medical conditions or surgeries:

Do any of your close relatives have (family eye history):

Check all that apply:

☐ Glaucoma ☐ Retinal detachment ☐ Macular degeneration ☐ Diabetes ☐ Other

LIFESTYLE & EYE HISTORY

Do you currently smoke?		☐ Yes	☐ No
Have you smoked in the past?		☐ Yes	☐ No
Are you pregnant or nursing?		☐ Yes	☐ No
Do you drive?		☐ Yes	☐ No
Have you had LASIK, PRK, or RK?	Date:	☐ Yes	☐ No
Do you wear contact lenses?		☐ Yes	☐ No
If yes, type: ☐ Hard / RGP ☐ Soft ☐ Toric ☐ Multifocal			
Have you had a flu vaccine?	Date:	☐ Yes	☐ No
Have you had a pneumonia vaccine?	Date:	☐ Yes	☐ No

Date of last eye exam

Eye exam provider

How old are your current glasses?

Where were they purchased?

Preferred pharmacy & location

CURRENT MEDICATIONS & ALLERGIES

List all prescription medicines, over-the-counter medicines, and supplements you take.

Medication / supplement	Dose	How often	How taken	Reason taken

Do you now take, or have you ever taken, tamsulosin (Flomax)? ☐ Yes ☐ No

Medication allergies:

☐ No known drug allergies

List any drug allergies