John W. Dresely, Jr., O.D., PLLC

Patient Registration and Health History

Patient's Name (Mr Mrs Ms Dr) _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age ____ Sex M ___ F ___ E-Mail Address _____

Home # _____ Work # _____ Cell # _____

In what ways may we contact you? Phone _____ E-Mail _____ Text _____

Social Security # _____

Occupation _____ Place of Employment _____

Marital Status _____ Spouse's Employer _____

Person to Notify in Case of Emergency _____ Phone # _____

How did you first find out about our office? _____

What is the main reason for your visit today? _____

Are you interested in learning more about laser vision correction? Y ____ N ____

Eye and Health History

Are you taking any medications? Y N
Specify _____
Are you allergic to any medications? Y N
Specify _____
Do you have any seasonal or environmental allergies? Y N
Specify _____
When was your last physical? _____
Are you currently pregnant? Y N
Due Date _____

Do you wear eye glasses? Y N
Previous eye doctor's name _____
Date of last eye exam _____
Have you ever had any surgery or injury to your eyes? Y N
Do you use a computer? Y N
How many hours a day? _____
Does computer use give you any symptoms? Y N

Do you or any family member have any of the following? Put an **S** if self, **F** if family

___ Cataracts
___ Glaucoma
___ Macular degeneration
___ Lazy eye/Amblyopia
___ Eye turn
___ Color blindness
___ Flashes or floating spots
___ Retinal detachment
___ Vision therapy
___ Diabetes
___ Thyroid disorder
___ Asthma/lung disorders
___ Arthritis/joint problems
___ Hearing problems
___ Intestinal/digestive disorders
___ Cancer/tumors
___ High blood pressure
___ Heart problems
___ Neurological problems
___ Mental health disorders
___ Skin or breast disease
___ High cholesterol

Contact Lens Information

Have you ever worn contact lenses? Y N
Do you wear contact lenses now? Y N
How often do you replace them? _____
Are you having any comfort problems? Y N
Are you interested in contact lenses today? Y N
Are you interested in changing your eye color? Y N

What type have you worn in the past?
_____
Do you sleep in your lenses? Y N
Would you like to be able to wake up wearing your lenses? Y N