DR. DON STOVER OPTOMETRY
PATIENT REGISTRATION

Name:_____ **Birth Date:**____/____/____

Home Phone:_____**Cell Phone:**_____
May we text message you? Y N
Address:_____**City:**_____

State:_____ **Zip:**_____

Social Security:_____-____-_____

Patients Employer or School:_____

Occupation:_____**Work Phone:**_____

Spouses Name:_____

Insurance: (If subscriber of policy is other than patient)

Subscriber:_____**Birth Date:**____/____/_____
Insurance Co:_____**Social Security:**_____-____-_____
Insurance Subscriber ID#_____

If patient is a minor list adult responsible for this account:

Name:_____**Social Security**_____-____-_____

Do you currently wear glasses or contacts?_____

Whom may we thank for referring you?_____

Date: | Date Of Last Eye Exam:
Patient: | Birthdate:
Address: | Age:
Referred By: | Sex:
Emergency Contact: | Emergency Contact Telephone:

REVIEW OF HEALTH SYSTEMS ◆ (ROS)

◆EYES Have you had or do you have any of the following?

Glaucoma:	☐Yes ☐No	Explain:
Cataracts:	☐Yes ☐No	Explain:
Dry Eyes:	☐Yes ☐No	Explain:
Other eye problems:	☐Yes ☐No	Description:

Please describe any problems with the following health systems:

◆GASTROINTESTINAL ☐ No Problem
☐ Ulcer ☐ Colitis ☐ Heartburn ☐ Diarrhea
☐ Other:
Meds:

◆ NEUROLOGICAL ☐ No Problem
☐ Epilepsy ☐ Multiple Sclerosis ☐ Headaches ☐ Numbness
☐ Other:
Meds:

◆ EARS/NOSE/THROAT ☐ No Problem
☐ Upper Respiratory Infection ☐ Sinusitis ☐ Chronic colds
☐ Other:
Meds:

◆ CONSTITUTIONAL ☐ No Problem
☐ Fever ☐ Weight Loss ☐ Fatigue ☐ Developmental Disability
☐ Trauma ☐ Other:
☐ Meds:

◆ CARDIOVASCULAR ☐ No Problem
☐ High Blood Pressure ☐ Heart Disease ☐ Vascular Disease ☐ Stroke
☐ High Cholesterol ☐ Chest Pain ☐ Irregular Heart Beat ☐ Other:
Meds:

◆ MUSCULOSKELETAL ☐ No Problem
☐ Muscular Dystrophy ☐ Osteoarthritis ☐ Joint Pain ☐ Muscle Aches
☐ Other:
Meds:

◆ RESPIRATORY ☐ No Problem
☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Wheezing ☐ Coughing
☐ Other:
Meds:

◆ INTEGUMENTARY (SKIN) ☐ No Problem
☐ Psoriasis ☐ Eczema ☐ Rashes ☐ Acne ☐ Cancer
☐ Excessive Dryness ☐ Other:
Meds:

◆ ALLERGIC/IMMUNE ☐ No Problem
☐ Allergies:_____ ☐ Rheumatoid Arthritis
☐ Drug allergies:_____ ☐ Lupus ☐ HIV
☐ Meds:

◆ ENDOCRINE (GLANDS) ☐ No Problem
☐ Thyroid Dysfunction ☐ Hormonal Dysfunction
☐ Type 1 Diabetes ☐ Type 2 Diabetes
Meds:

◆ BLOOD / LYMPH ☐ No Problem
☐ Anemia ☐ Leukemia
☐ Other:
Meds:

◆ PSYCHIATRIC (MENTAL) ☐ No Problem
☐ Depression ☐ Bipolar ☐ ADD/ADHD
☐ Other:
Meds:

◆ GENITOURINARY ☐ No Problem
☐ STD ☐ Bladder Infection ☐ Blood in Urine
☐ Other:
Meds:

PAST, FAMILY, & SOCIAL HISTORY ★ (PFSH)

★ PATIENT PAST HISTORY
Have you had any eye operations? ☐Yes ☐No Date:_____ Type:_____
Have you had an eye injury? ☐Yes ☐No Date:_____ Type:_____
Have you had a retinal detachment? ☐Yes ☐No Date:_____ Treatment:_____
Name of family doctor: _____ Pharmacy:_____
List any eye medications you are currently taking:

★ SOCIAL HISTORY
Do you use alcohol? ☐Yes ☐No Amount:_____
Smoking Status: ☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never smoked ☐ Unknown
Do you use other substances? ☐Yes ☐No What:_____
Describe any special visual needs:

Height: **Weight:**
Race: ☐ Native American ☐ Asian ☐ White ☐ Pacific Islander ☐ African American
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic/Latino
Preferred Language: ☐ English ☐ Spanish ☐ Other:

★ FAMILY HISTORY Do any family members have any of the following problems:

High blood pressure	☐Yes ☐No	Relation _____	Macular Degeneration	☐Yes ☐No	Relation _____
Diabetes	☐Yes ☐No	Relation _____	Retinal Detachment	☐Yes ☐No	Relation _____
Glaucoma	☐Yes ☐No	Relation _____	Cataracts	☐Yes ☐No	Relation _____
Other eye condition	☐Yes ☐No	Relation _____ Description:_____			

☐ I give permission to obtain my medical prescription history. _____

Patient Signature: _____

Date Reviewed — Changes

_____ ☐ No Changes _____
_____ ☐ No Changes _____
_____ ☐ No Changes _____
_____ ☐ No Changes _____

FOR OFFICE USE ONLY

◆ROS ELEMENTS ☐ PP=1 ☐ Ext=2-9 ☐ Comp= 10-14

★ PFSH AREAS ☐ 1 ☐ 2 ☐ 3

Dr. Init	Review Date	ROS Elements	PFSH Areas