FENWAY HEALTH

Optometry Registration

The information in your medical record is confidential and is protected under Massachusetts General Laws Ch. 111, Sec 70. Your written consent will be required for release of information except in the case of a court order.

Medical Record #
(For office use only)

Legal Name Last First Middle Initial

Date of Birth *Month Day Year*
/ /

Name Used:

Ocular History

Date of last eye exam:

Location of last eye exam:

Please list any eye problems you are currently having

Do you currently wear?
- ☐ Glasses
- ☐ Contact lenses

Are you interested in?
- ☐ Contact lenses
- ☐ Laser vision correction

Have you had any past?
- ☐ Eye injury
- ☐ Eye surgery

Are you currently experiencing?
- ☐ Blurred vision
- ☐ Flashes
- ☐ Floaters
- ☐ Double vision
- ☐ Headache
- ☐ Loss of vision
- ☐ Eye pain

Do you have any of the following conditions?
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Retinal disease
- ☐ Herpes simplex or zoster
- ☐ Amblyopia (lazy eye)

Social History

What is your occupation?

Do you have any special visual needs or hobbies?

Do you?

Smoke tobacco
- ☐ Current
- ☐ Past history

Drink alcohol
- ☐ Current
- ☐ Past history

Use recreational drugs
- ☐ Current
- ☐ Past history

Family History

Do you have any family members with the following eye conditions?
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Retinal detachments
- ☐ Other_____

Do you have any family members with the following medical conditions?
- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Other_____

Medical History

Please list any medication(s) you are currently taking

☐ none ☐ my PCP is at Fenway Health (see med list in chart)

Please list any allergies to medications

☐ none

Are you currently?
- ☐ Pregnant
- ☐ Nursing

FENWAY HEALTH

Review of Systems - Are you currently having problems with any of the following?

General/Constitutional ☐ Weight loss/gain ☐ Fatigue ☐ Weakness ☐ Fever/chills ☐ Other_____ ☐ None	**Eyes** ☐ Redness ☐ Itchiness/burning ☐ Dryness ☐ Discharge ☐ Other_____ ☐ None	**Ears/Nose/Throat** ☐ Decreased hearing ☐ Ringing ☐ Congestion ☐ Sinus problems ☐ Other_____ ☐ None
Cardiovascular ☐ Chest pain ☐ High blood pressure ☐ Heart problems ☐ High cholesterol ☐ Other_____ ☐ None	**Respiratory** ☐ Coughing/wheezing ☐ Shortness of breath ☐ Asthma ☐ Tuberculosis ☐ Other_____ ☐ None	**Gastrointestinal** ☐ Swallowing difficulty ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Other_____ ☐ None
Musculoskeletal ☐ Muscle pain ☐ Joint pain/swelling ☐ Muscle weakness ☐ Arthritis ☐ Other_____ ☐ None	**Integumentary/Skin** ☐ Bruising easily ☐ Dryness/itching ☐ Rash ☐ New or changing moles ☐ Other_____ ☐ None	**Neurological** ☐ Headache ☐ Seizures ☐ Numbness/tingling ☐ Dizziness ☐ Other_____ ☐ None
Psychiatric ☐ Depression ☐ Stress ☐ Nervousness ☐ Poor concentration ☐ Other_____ ☐ None	**Endocrine** ☐ Thyroid problems ☐ Diabetes ☐ Cold interolerance ☐ Excessive thirst ☐ Other_____ ☐ None	**Hematological/Lymphatic** ☐ Abnormal bleeding ☐ Anemia ☐ Clotting disorders ☐ Other_____ ☐ None
Genitourinary ☐ Blood in urine ☐ Frequent urination ☐ Sexually transmitted infection ☐ Other_____ ☐ None	**Allergic/Immunologic** ☐ HIV ☐ Lupus ☐ Rheumatoid arthritis ☐ Seasonal allergies ☐ Other_____ ☐ None	

Returning Patients:

Please review information on this form and make any necessary corrections. Initial and date on one line below indicating updates are complete.

Date: _____ Initial: _____ Date: _____ Initial: _____

Date: _____ Initial: _____ Date: _____ Initial: _____

Date: _____ Initial: _____ Date: _____ Initial: _____