CLEARSIGHT OPTOMETRY
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Phone: (408) 300-0717 Fax (888) 604-2519

REGISTRATION AND HEALTH HISTORY

Name ☐Mr. ☐Ms. ☐Mrs. _____ **DOB** _____ **Age** _____ **Date** _____

Parent's name (provide if patient is a minor)_____

Mailing address _____**City**_____**State**_____**Zip code** _____

Primary Phone (_____)_____**Type:** ☐Cell ☐Home **Emergency contact phone** (_____)_____ **Type** ☐Cell ☐Home

Email Address_____ **Occupation** ☐Student ☐Other _____

Insurance: **Patient's relationship to the insured** ☐Self ☐Spouse ☐ Dependent Insured's last 4 digits of social security # _____

Insured's name _____ Insurance plan name _____

Insured's date of birth _____ Insured's ID _____

Insured's employer _____ Insured's Group# _____

Reason for your visit: ☐Blurry vision at distance ☐Blurry vision at near ☐Interested in contact lenses ☐Routine Eye exam ☐ Red Eye

☐Other_____

_____

Please check all box (es) that apply to you and your immediately family:

☐**No change in history since last visit**

	Patient's Ocular Hx	**Family's Ocular Hx**		**Patient's Medical Hx**	**Family's Medical Hx**
No ocular health problem	☐	☐	No medical problem	☐	☐
Blindness	☐	☐	ABNORMAL headache	☐	☐
Blackout in vision	☐	☐	Allergy	☐	☐
Variable vision	☐	☐	Asthma	☐	☐
Double vision	☐	☐	Cancer	☐	☐
Eye injury	☐	☐	Diabetes	☐	☐
Eye Strain	☐	☐	Heart disease	☐	☐
Flashes of light	☐	☐	High cholesterol	☐	☐
Glaucoma	☐	☐	High blood pressure	☐	☐
Lazy eye/crossed eye	☐	☐	Kidney problem	☐	☐
Macular Degeneration	☐	☐	Thyroid abnormality	☐	☐
Poor color vision	☐	☐	Tuberculosis	☐	☐

Do you have other health issue not mentioned above? ☐No ☐Yes If yes, please explain: _____

Are you **allergic to any medication**? ☐No ☐Yes If yes, which medication(s) are you allergic to?_____

Have you had any serious eye disease, injury or surgery? ☐No ☐Yes If yes, please explain: _____

Have you worn contact lenses before? ☐No ☐Yes, currently using _____ ☐Yes, but not anymore

Was your last eye exam at our office? ☐No ☐Yes If yes, when was your last eye exam?_____

Do you smoke? ☐No ☐Yes

If you are a woman, are you pregnant? ☐No ☐Yes ☐ N/A Are you breastfeeding? ☐No ☐Yes ☐ N/A

Signature (parent, if minor)_____ **Date**_____