Scarbrough Family Eyecare
Scarbrough Professional Services, P.C.
527 West Front Street
Traverse City, Michigan 49684
(231) 947-8667
www.ScarbroughFamilyEyecare.com

Patient Registration

Date:_______________________

Please review, make necessary changes and supply any missing information.

Patient Name:		Nickname:
Date of Birth:	Age:	Marital Status:
Sex:		SS #

Mailing Address:

City: **State:** **Zip Code:**

Communication		
Home Phone #	Work Phone #	Extension:
Cell Phone #		

EMAIL:

Your email address is used to send the results of your exam to you and for recall purposes. Declined: ____

Information

Primary Language (check one):	Race (check one):	Ethnicity (check one):
English _____	American Indian or Alaska Native ____	Not Hispanic or Latino ____
Spanish _____	Asian ____	Hispanic or Latino ____
French _____	Black or African American ____	Decline to specify ____
Other _____	Native Hawaiian/Pacific Islander ____	
Decline to specify _____	White ____	
	Decline to specify ____	

Occupation:	Employer:

Account Responsible

Responsible:	
Relationship:	SS #

Mailing Address:

City: **State:** **Zip Code:**

Home Phone #	Work Phone #	Extension:

Emergency Contact

First:	Last:	Relation:	Home #	Cell #	Work #

NEW PATIENTS ONLY - How did you hear about us?

Friend or Family?________________________________ **Yellow Pages** ____ **Insurance Co.** ____

Website ____ **Office Location/Sign** ____ **Other**____________________

**We would like to thank our patients that refer to us. Please make sure to list their name if someone referred you.

Patient Health History

Please review, make necessary changes and supply any missing information.

Patient Name:		Date of Birth:
Primary Care Physician:	Reason for Last Visit:	Approximately when was your last visit:
New Patients only: Last Eye Doctor:		New Patients only: Date of last eye exam: Dilated: Yes___ No___

Medical History			
Please list any *CURRENT* illnesses, symptoms or problems:			
Heart / Blood Pressure		Nerves / Brain	
Ears, Nose, Throat		Psychiatric	
Breathing		Kidneys / Thyroid	
Stomach		Blood	
Urinary / Reproductive		Allergies (not medications)	
Bones / Joints / Muscles		Diabetes	
Skin		Headaches	
Other			

Do you work on a computer?	Hours per day:

Diabetic Information	
Blood Sugar test: Value/Reading:______________	A1c test : Value/Reading:______________

Eye Surgery Information	
Procedure:	Eye:

Past / Present Eye History		
Please list any past or present EYE illnesses, symptoms or problems:		
	Self:	Family:
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Other Disease		
Blindness		
Lazy Eye		
Diabetes		
Dry Eye		
Refractive		

Social History

Are you a smoker, former smoker or never smoked? ______________________________

Do you smoke everyday or some days? ______________________________

Occupation:

Lifestyle Information:

Please circle any of the following that pertain to you:

Drive a lot at night   Work outside in the sun   Hazardous job; construction, etc.   Walking; Running; Biking

Read for work/Pleasure   Shooting sports; hunting, etc.   Water sports; fishing, etc.   Team sports; baseball etc.

Other special vision needs: ____

Current Medications
(OR WE CAN COPY YOUR MEDICATION LIST)

Please cross out any medications that you are no longer taking
Please list all prescriptions, over the counter and herbal medications

Date	Name	Strength	Directions

Are you allergic to any medications,? If yes, please list:

Contact Lens History

Type of contact lenses you currently use (gas permeable, soft daily, extended)			**How often do you replace your contacts?** (daily, weekly, monthly)		
Average number of hours that you wear your contacts		**Number of hours worn today**		**Wearing Type** (daily, weekly, 2 weeks, monthly, extended)	

Pupil Dilation:

To perform a comprehensive eye examination it may be necessary for the doctor to dilate your pupils with eye drops. The side effects of pupil dilation can last for several hours and include: sunlight sensitivity and possible blurred vision. Some patients prefer to have someone drive them home following pupil dilation.

If found necessary, I prefer to be dilated: ____ Today ____ Some other day ____ Prefer not to be dilated