Eye Specialists of Colorado

Better Vision for a Better Life

Patient Registration Form

Today's date _____

Please present a photo ID and insurance cards to the front desk prior to filling out your paperwork.

Patient Name: _____
Last *First* *MI*

Nickname (*if applicable*): _____

DOB: _____/_____/_____ Gender (circle): Male/Female

Address: _____
Street *Apt#* *City* *State* *Zip*

Phone: (___) _____ Home/Cell/Work May we leave a message? Y/N

Phone: (___) _____ Home/Cell/Work May we leave a message? Y/N

Email: _____ SSN#: _____-_____-_____
(Email is used for future appointment confirmation and office correspondence only)

Emergency Contact: _____ Phone: _____

Ethnicity (*circle*): African-American /Asian / Caucasian / Latino / Native American / Other

Occupation (*please notate if you are retired*): _____

Health Insurance Name: _____ Vision Plan: _____

Primary Care Physician

Name _____

Address _____

Phone _____

Preferred Pharmacy

Name _____

Address _____

Phone _____

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Past Medical History

Please select any of the following conditions you currently have

__ Anxiety
__ Arthritis
__ Asthma
__ Atrial Fibrillation
__ Bone Marrow Transplant
__ BPH
__ Breast Cancer
__ Colon Cancer
__ COPD
__ Coronary Artery Disease
__ Depression
__ Diabetes
__ End Stage Renal Disease
__ GERD
__ Hearing Loss
__ Hepatitis
__ Hypertension
__ HIV/AIDS
__ Hypercholesterolemia
__ Hyperthyroidism
__ Hypothyroidism
__ Leukemia
__ Lung Cancer
__ Lymphoma
__ Prostate Cancer
__ Radiation Treatment
__ Seizures
__ Stroke
__ None
__ Other
_____
_____
_____

Past Surgical History

Please list any past surgeries

_____ _____
_____ _____
_____ _____

List any medications you are currently taking (prescription and over the counter)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

List any allergies that you are aware of

_____ _____ _____
_____ _____ _____

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Past Ocular History

Please check all that apply

__ None

__ Allergic Conjunctivitis L R

__ Blepharitis L R

__ Cataract L R

__ DSEK L R

__ Corneal Dystrophy L R

__ Diabetic Retinopathy L R

__ Dry Eyes L R

__ Glaucoma L R

__ Macular Degeneration L R

__ Macular ERM L R

__ Narrow Angles L R

__ Ocular Hypertension L R

__ Ophthalmic Migraine L R

__ Pseudoexfoliation L R

__ Retinal Tear L R

__ Strabismus L R

__ PVD L R

__ Vitreous Floaters L R

Past Ocular Surgery

Please check all that apply

__ None

__ Blepharoplasty L R

__ Cataract Surgery L R

__ Corneal Transplant L R

__ DSEK L R

__ Eye Muscle Surgery L R

__ Intravitreal Injections L R

__ ALT/SLT L R

__ PRK L R

__ Ptosis Repair L R

__ Punctal Plugs L R

__ Strabismus L R

__ Retinal Laser L R

__ Trabeculectomy L R

__ Tube Shunt L R

__ YAG capsulotomy L R

_____ L R

_____ L R

_____ L R

Family History (*Please check all that apply)*

M-Mother/F-Father/S-Sister/B-Brother

Diabetes	__M	__F	__S	__B	Heart Disease	__M	__F	__S	__B
Hypertension	__M	__F	__S	__B	Migraine	__M	__F	__S	__B
Glaucoma	__M	__F	__S	__B	Cancer	__M	__F	__S	__B
Blindness	__M	__F	__S	__B	Stroke	__M	__F	__S	__B
Cataract	__M	__F	__S	__B	Macular Degeneration	__M	__F	__S	__B
Strabismus	__M	__F	__S	__B	Retinal Detachment	__M	__F	__S	__B

Other _____ _____ _____

Do you smoke? (circle) Y / N If yes, indicate how much you smoke daily _____