

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

1144 Beulah Hwy
Beulah, MI 49617
231-882-5542

www.ScarboroughFamilyEyecare.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): English _____ Spanish _____ French _____ Other _____ Decline to specify _____	Race (check one): American Indian or Alaska Native _____ Asian _____ Black or African American _____ Native Hawaiian/Pacific Islander _____ White _____ Decline to specify _____	Ethnicity (check one): Not Hispanic or Latino _____ Hispanic or Latino _____ 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? _____ Traverse Magazine _____ Google Reviews _____

Facebook _____ Website _____ Insurance _____ Other _____

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:
<u>New Patients only:</u> Last Eye Doctor:		<u>New Patients only:</u> Date of last eye exam: Dilated: Yes____ No____

Medical History			
Please list any <i>CURRENT</i> 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:
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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: _____
Migraines
Do you suffer from Migraines? If so, how often do you experience them? _____ _____

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 dilate

