📋 BLOOMFIELD EYE ASSOCIATES – PATIENT REGISTRATION FORM

| Patient Name | _____ **| Date of Birth |** _____ **|**

📞 Communication Information

Home Phone #_____ **Cell Phone #**_____

🌐 Personal Information

Primary Language _____ **Marital Status** _____

Race _____ **Ethnicity** _____

Occupation _____ **Employer** _____

🚨 Emergency Contact

| Name and Contact # | _____ **|**

👨‍⚕️ Medical Providers

Primary Care Physician _____ **Phone #**_____

Last Eye Doctor _____ **Duration since last eye exam?** _____

🩺 Review of Systems

Please list any current illnesses, symptoms, or problems in each category:

System	Details
Constitutional	_____
Cardiovascular	_____
Ears, Nose, Mouth, Throat	_____
Respiratory / Lungs	_____
Stomach / Intestines	_____
Urinary / Reproductive	_____
Bones / Joints / Muscles	_____
Skin / Hair / Nails	_____
Neurological	_____
Psychiatric	_____

System	Details
Endocrine / Hormonal	_____
Blood / Circulation	_____
Allergic / Immunologic	_____
Other	_____

| **Are you pregnant and/or nursing?** | Yes ☐ No ☐ | Due Date: _____ |

🛠️ Surgical History

Date	Procedure / Surgeon	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

👁️ Ocular History

Condition	Additional Details	Age of Onset	Years (from – to)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

| **Do you wear glasses?** | Yes ☐ No ☐ |

| **Do you wear contact lenses?** | Yes ☐ No ☐ |

🩺 Personal Medical History

Condition	Additional Details	Age of Onset	Year (from – to)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

🚀 Social History: List your social history and detail frequency.

Description	Additional Details	Age Began	Year (from – to)
Exercise	_____	_____	_____
Drugs	_____	_____	_____
Alcohol Use	_____	_____	_____
Tobacco Use	_____	_____	_____

Have you ever been exposed to or infected with any of the following?

HIV ☐ AIDS ☐ Hepatitis C ☐ Gonorrhea ☐ Syphilis ☐ TB ☐

🧬 Family Medical History

Family Member	Medical Condition	Age of Onset
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

🌿 Allergies

Allergy	Onset Date	Reaction	Severity
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

💊 Medications

(Use additional sheet if needed)

Medication Name	Strength	Directions	Date Started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____