VICTORIAEYE
LASERS • SPECIALISTS • SURGERY

PATIENT REGISTRATION FORM

NAME: _____ **DATE OF BIRTH:** _____

BC CARE CARD NUMBER: _____ **LANGUAGE:** _____

ADDRESS: _____ **CITY:** _____

POSTAL CODE: _____ **PROFESSION (or previous):** _____

PHONE: _____ **CELL:** _____ **EMAIL:** _____

FAMILY DOCTOR: _____ **OPTOMETRIST:** _____

SMOKER: No ☐ Yes ☐ **if yes, how many per day:** _____

ALLERGIES:

☐ **None** ☐ Penicillin ☐ Sulpha ☐ Latex ☐ Codeine ☐ Moxifloxacin ☐ Ciprofloxacin

☐ Other or Non-medical: _____

PLEASE CHECK THE APPROPRIATE BOXES IF THEY APPLY TO YOU: ☐ **None**

☐ Stroke	☐ Bleeding disorder	☐ Sleep apnea
☐ Heart disease	☐ Sjogren's Syndrome	☐ Pacemaker
☐ Claustrophobic	☐ High Blood Pressure	☐ Dementia
☐ Hay fever	☐ COPD (asthma/emphysema)	☐ Anemia
☐ Osteoporosis	☐ High cholesterol	☐ Alcoholism
☐ Migraine headaches	☐ Mental Illness (depression/anxiety)	☐ HIV/HIV+ Status
☐ Thyroid Disease	☐ Skin disorder (eczema/psoriasis)	☐ Cancer
☐ Auto-immune Disease	☐ Blood Transfusion	☐ Osteoarthritis
☐ Corneal Herpes	☐ Keloid Scarring	☐ Rheumatoid arthritis
☐ Sexually Transmitted Disease	☐ VRE (Vancomycin Resistant Enterococci)	☐ Hepatitis B or C

☐ MRSA (Methicillin Resistant Staphylococcus Aureus)

☐ Pregnant or Nursing (within last 3 months or considering within 6 months)

☐ Diabetes **If yes**: ☐ Insulin since: _____

Or ☐ Medication since: _____

Or ☐ Diet controlled since: _____

Who is your Internist/Endocrinologist: _____

2 sided form, please complete both sides

DO YOU WEAR CONTACT LENSES? ☐ **Yes** ☐ **No** **If yes:**

LENS TYPE: ☐ Soft ☐ Toric ☐ Rigid Gas Permeable ☐ Hard

FREQUENCY: ☐ Daily ☐ Few days/week ☐ Sports/events ☐ Rarely

PAST SURGICAL HISTORY: ☐ **None**

☐ Tonsils ☐ Appendix ☐ Heart ☐ Gallbladder ☐ Hysterectomy

☐ Other: _____

DIAGNOSED EYE PROBLEMS: ☐ **None**

☐ Cataracts ☐ Glaucoma ☐ Lazy Eye ☐ Prism in glasses ☐ Retinal problems

☐ Corneal Disease ☐ Injury ☐ Keratoconus ☐ Other: _____

PREVIOUS EYE SURGERY: ☐ **None**

☐ Cataract: ☐ Right by Dr. _____ Year _____ ☐ Left by Dr. _____ Year _____

☐ Other: ☐ Right by Dr. _____ Year _____ ☐ Left by Dr. _____ Year _____

Surgery type: _____

FAMILY HISTORY OF EYE PROBLEMS AND RELATIONSHIP: ☐ **None**

☐ Macular Degeneration _____

☐ Lazy Eye_____

☐ Glaucoma _____

☐ Retinal Detachment _____

☐ Other: _____

ARE YOU CURRENTLY TAKING THE FOLLOWING BLOOD THINNERS: ☐ **None**

☐ Coumadin ☐ Warfarin ☐ Plavix ☐ Aspirin ☐ Imitrex (migraines) ☐ Accutane

LIST ALL EYE MEDICATIONS/DROPS

_____

_____

_____

_____

LIST ALL OTHER MEDICATIONS
(INCLUDE LIST WITH DOSAGE INFORMATION)

_____

_____

_____

_____

Signature: _____ Date: _____