Low Vision Institute

Date of Service : ____/_____/_____

REGISTRATION

WELCOME TO THE LOW VISION INSTITUTE: If this is your first visit, please complete this form and present it to the receptionist along with your driver's license and insurance card. If you are a previous patient please update any information that has changed since your last visit.

Please print clearly.

Patient Name: _____Male __ Female __ Single __ Married __

Address: _____ Apt. #_____

City:_____ State: _____ Zip Code: _____ Is this a Nursing Facility? ❑Y ❑N

Home Phone: _____ Work or Cell: _____

Social Security #: _____ Date of Birth: ____/___/_____ Age _____

Email Address (print clearly): _____

Occupation: _____ Employer _____

Emergency Contact: _____Relationship: _____Phone: _____

Referred By:_____

First heard of the Low Vision Institute: Radio __ TV __ Article __ Cooking Without Looking __ LVI Patient ___

Heard Dr. Gannon Speak __ Magazine/ Newspaper ad (which one) _____Other: _____

Primary Eye Doctor: _____ Retinal Doctor: _____

Family Doctor: _____ Dentist: _____

Clergy: _____ Church/ Temple: _____

Primary Insurance Carrier: _____

Name of Insured: _____ Relationship _____

Secondary Insurance Carrier: _____

Name of Insured: _____ Relationship _____

What Low Vision aids do you presently use? _____

Were they Prescribed? ❑Y ❑N If yes, where and when: _____

Insurance Authorization: I hereby authorize Dr. Marc Jay Gannon to furnish information to insurance carriers concerning my illness, accident and/or treatments. I also hereby authorize them to obtain copies of my medical records from other physicians if necessary. A photocopy of this authorization shall be considered as effective and valid as the original. I irrevocably assign all insurance payments directly to Dr. Marc Jay Gannon. I also accept financial responsibility for any services, or portions of services provided to me that are not covered by my insurance. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

Patient LIfetime Signature: _____ Date ____/___/_____

Low Vision Institute

Patient Name:_____
Date: ____/_____/_____
Primary Care Physician_____Phone ____-____-_____
Opthalmologist _____Phone ____-____-_____

MEDICAL HISTORY

EYE HISTORY: check conditions you've had or currently have

- ❑ Cataracts
  - ❑ Extraction from Left Eye?
  - ❑ Extraction from Right Eye?
- ❑ Macular Degeneration
  - ❑ Have you had Laser Treatments?
    - ❑ Left Eye?
    - ❑ Right Eye?
  - ❑ Have you had injections?
    - ❑ Left Eye?
    - ❑ Right Eye?
  - ❑ I have had no treatments
- ❑ Eye Injury? _____
- ❑ Eye Disease? _____
- ❑ Eye Surgery? _____
- ❑ Glaucoma? _____
- ❑ Blindness? _____
- ❑ Retinal Detachments? _____
- ❑ Strabismus? _____
- ❑ Other (Please specify): _____

MEDICAL HISTORY: please check all that apply

❑ High Blood Pressure	❑ Arthritis	❑ Diabetes
❑ Lupus	❑ Tuberculosis	❑ Anemia
❑ Heart Attack	❑ High Cholesterol	❑ Cancer
❑ Coronary Artery Disease	❑ Thyroid Disease	❑ Stroke
❑ Hypertension	❑ Asthma	❑ MS
❑ Cancer	❑ Nervous Condition	❑ Depression
❑ Emphysema	❑ Other (Please specify):_____	

FAMILY HISTORY: please check all that apply

❑ Blindness	❑Mother	❑Father	❑Sibling	❑ Hypertension	❑Mother	❑Father	❑Sibling
❑ Glaucoma	❑Mother	❑Father	❑Sibling	❑ Thyroid Dis	❑Mother	❑Father	❑Sibling
❑ Diabetes	❑Mother	❑Father	❑Sibling	❑ Cataract	❑Mother	❑Father	❑Sibling

❑ Other (Please specify): _____

SOCIAL HISTORY:

Do you smoke?	❑Y ❑N	Packs/day: _____
Do you drink alcohol?	❑Y ❑N	Drinks/day: _____
Do you do illegal drugs?	❑Y ❑N	
Do you have HIV/ AIDS?	❑Y ❑N	
Have you had	❑Gonnorhea ❑Syphillis ❑Hepatitis	

Low Vision Institute

Patient Name:_____
Date: ____/_____/_____

REVIEW OF SYSTEMS

Please check "Yes" or "No" to all.

CONSTITUTIONAL:
Weight Loss ❑Y ❑N
Weight Gain ❑Y ❑N
Fever ❑Y ❑N
Fatigue ❑Y ❑N
Change in Appetite ❑Y ❑N
Other: _____

SKIN
Rash/ Sores ❑Y ❑N
Lesions ❑Y ❑N
Other: _____

NEUROLOGICAL
Headaches ❑Y ❑N
Migraines ❑Y ❑N
Seizures ❑Y ❑N
Tremors ❑Y ❑N
Numbness ❑Y ❑N
Dizziness ❑Y ❑N
Other: _____

EYE
Loss of Central Vision ❑Y ❑N
Loss of Side Vision ❑Y ❑N
Sudden Blindness ❑Y ❑N
Double Vision ❑Y ❑N
Dryness ❑Y ❑N
Redness ❑Y ❑N
Itching ❑Y ❑N
Eye Pain ❑Y ❑N
Mucous Discharge ❑Y ❑N
Watering/ Tearing ❑Y ❑N
Eyelid Infections ❑Y ❑N
Sandy / gritty feeling ❑Y ❑N
Styes or Chalazion ❑Y ❑N
Flashing Lights ❑Y ❑N
Floating Spots ❑Y ❑N
Halos Around Lights ❑Y ❑N
Eye Fatique ❑Y ❑N
Fluctuating Vision ❑Y ❑N
Blurriness/ Distortion ❑Y ❑N
Night Vision Problems ❑Y ❑N
Glare / Light Sensitivity ❑Y ❑N
Other: _____

ENDROCRINE
Thyroid Problems ❑Y ❑N
Glandular Disorders ❑Y ❑N
Other: _____

EAR, NOSE, MOUTH, THROAT
Allergies ❑Y ❑N
Hay Fever ❑Y ❑N
Runny Nose ❑Y ❑N
Chronic Cough ❑Y ❑N
Sinus Congestion ❑Y ❑N
Post Nasal Drip ❑Y ❑N
Dry Throat/ Mouth ❑Y ❑N
Frequent Nosebleeds ❑Y ❑N
Hoarseness ❑Y ❑N
Vertigo ❑Y ❑N
Frequent Sore Throat ❑Y ❑N
Other: _____

RESPIRATORY
Shortness of Breath ❑Y ❑N
Coughing Blood ❑Y ❑N
Wheezing ❑Y ❑N
Frequent Infections ❑Y ❑N
Other:_____

CARDIOVASCULAR
Chest Pain ❑Y ❑N
Shortness of Breath ❑Y ❑N
Swelling ❑Y ❑N
Palpitations ❑Y ❑N
Other: _____

GASTROINTESTINAL
Abdominal Pain ❑Y ❑N
Nausea/Vomiting ❑Y ❑N
Heartburn ❑Y ❑N
Diarrhea ❑Y ❑N
Constipation ❑Y ❑N
Bloody Stools ❑Y ❑N
Other:_____

GENITOURINARY
Pain While Urinating ❑Y ❑N
Blood in Urine ❑Y ❑N
Other:_____

BONES/ JOINTS/ MUSCLES
Joint Pain ❑Y ❑N
Muscle Pain ❑Y ❑N
Back Pain ❑Y ❑N
Joint Stiffness ❑Y ❑N
Other: _____

LYMPHATIC/ HEMATOLOGIC
Anemia ❑Y ❑N
Bleeding Problems ❑Y ❑N
Bruising ❑Y ❑N
Enlarged Lymph Nodes ❑Y ❑N
Other: _____

ALLERGIC/ IMMUNE
Hives ❑Y ❑N
Hay Fever ❑Y ❑N
Other: _____

PSYCHIATRIC
Anxiety ❑Y ❑N
Depression ❑Y ❑N
Other: _____

Low Vision Institute

Patient Name:_____
Date: ____/_____/_____

MEDICATIONS & SURGERY

Please list all of the presciption medications you are currently taking.
Include any over the counter drugs/ vitamins.

Eye Medications

_____ _____ _____

_____ _____ _____

Systemic Medications

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any medications you are allergic to

_____ _____ _____

Please list all eye surgeries with dates

_____ _____ _____

_____ _____ _____

Please list all major surgeries

_____ _____ _____

_____ _____ _____