



**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 \_\_\_\_/\_\_\_\_/\_\_\_\_



Patient Name: \_\_\_\_\_  
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_-\_\_\_\_-\_\_\_\_  
Ophthalmologist \_\_\_\_\_ 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**

- |  |  |                                     |
|--|--|-------------------------------------|
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Diabetes   |
| <input type="checkbox"/> Lupus                   | <input type="checkbox"/> Tuberculosis                  | <input type="checkbox"/> Anemia     |
| <input type="checkbox"/> Heart Attack            | <input type="checkbox"/> High Cholesterol              | <input type="checkbox"/> Cancer     |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Thyroid Disease               | <input type="checkbox"/> Stroke     |
| <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Asthma                        | <input type="checkbox"/> MS         |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Nervous Condition             | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Other (Please specify): _____ |                                     |

**FAMILY HISTORY: please check all that apply**

- |  |                                 |                                 |                                  |                                       |                                 |                                 |                                  |
|--|---------------------------------|---------------------------------|----------------------------------|---------------------------------------|---------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> Blindness                     | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling |
| <input type="checkbox"/> Glaucoma                      | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling | <input type="checkbox"/> Thyroid Dis  | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling | <input type="checkbox"/> Cataract     | <input type="checkbox"/> Mother | <input type="checkbox"/> Father | <input type="checkbox"/> Sibling |
| <input type="checkbox"/> 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 Gonorrhea Syphilis Hepatitis



**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 Fatigue Y N
- Fluctuating Vision Y N
- Blurriness/ Distortion Y N
- Night Vision Problems Y N
- Glare / Light Sensitivity Y N
- Other: \_\_\_\_\_

**ENDOCRINE**

- 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: \_\_\_\_\_



Patient Name: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### MEDICATIONS & SURGERY

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

Eye Medications

_____	_____	_____
_____	_____	_____

Systemic Medications

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

Please list any medications you are allergic to

_____	_____	_____
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Please list all eye surgeries with dates

_____	_____	_____
_____	_____	_____

Please list all major surgeries

_____	_____	_____
_____	_____	_____