KLEMP OPTOMETRY
1910 IDAHO STREET
LEWISTON, ID 83501-2564
(208)743-4022

Patient Registration

Date:

Patient Name				**Phone**	
Date of Birth		**Age**		**Cell Phone**	
Sex				**Email**	
Address				**Address Type**	

Communications preference: ☐ Home phone☐ Cell phone☐ Work phone ☐ Text message ☐ Email ☐ U.S. Mail

The Federal Government now requires us to collect the following information:

Language	☐ English ☐ Spanish ☐ Mandarin ☐ Arabic ☐ French ☐ Other_____		
Race:	☐ Asian ☐ Black/African American ☐ Native American/Alaska Native	☐ Native Hawaiian or other Pacific Islander ☐ White/Caucasian ☐ Multiracial	☐ Decline to answer ☐ Other _____
Ethnicity:	☐ Hispanic/Latino	☐ Non-Hispanic/Latino	

SOCIAL HISTORY

Occupation (If retired, from where?) Employer

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No

If yes, please describe**:**

How many hours per day do you use digital devices e.g., computer/tablet/e-Reader/smartphone?

What distance do you view most of the above devices? 0-12 inches 13-24 inches 25+ inches

Are you currently pregnant or breastfeeding? If so, for how many months?

Do you use tobacco/nicotine products? ☐ Yes ☐ No If yes, type/amount/how long?

If former tobacco/nicotine user, how long ago did you quit?

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long?

Do you use recreational drugs? ☐ Yes ☐ No If yes, type/amount/how long?

Have you been exposed to/infected with: HIV ☐ Yes ☐ No Any other Sexually Transmitted Disease? ☐ Yes ☐ No

HOBBIES/RECREATION/SPORTS

Please mark all boxes that most accurately apply to you.

☐ Card playing ☐ Golf ☐ Team sports ☐ Flying ☐ Swimming ☐ Scuba Diving ☐ Boating ☐ Fishing ☐ Gardening
☐ Photography ☐ Crafts ☐ Sewing ☐ Hunting ☐ Darts ☐ Skiing ☐ Music ☐ Dancing ☐ Other outdoor activities
☐ Other_____

How did you hear about us? ☐ Friend ☐ Relative ☐ Insurance Company ☐ Facebook ☐ Other _____

Family members seen at Klemp Optometry _____

Internal Usage only: Patient: Acct: Today's Date:

OCULAR HISTORY

When and where was your last eye examination?

Indicate the visual correction that you wear. Please circle all that apply.

Glasses	Constant wear		Distance only	Reading only	
Contacts	Soft	Gas permeable	Are they comfortable?	☐ Yes	☐ No

How often do you replace your contacts? ☐ Daily ☐ 1-2 Weeks ☐ Monthly ☐ Other _____

What brand of contacts do you wear?

Which of the following have you had? ☐ Crossed eyes ☐ Lazy eye ☐ Drooping eyelid ☐ Eye infection ☐ Eye injury
☐ Glaucoma ☐ Cataracts ☐ Macular degeneration ☐ Other _____
☐ Eye surgery (Date and type e.g., cataract surgery or LASIK surgery)_____

Current eye symptoms – Do you experience any of the following with current spectacle/contact lens correction?

Blurred Vision	☐ Yes	☐ No	Flashing Lights	☐ Yes	☐ No	Seeing rings around lights	☐ Yes	☐ No
Distorted vision	☐ Yes	☐ No	Painful Eyes	☐ Yes	☐ No	Color vision difficulties	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Gritty/Sandy Eyes	☐ Yes	☐ No	Depth perception problems	☐ Yes	☐ No
Red eyes	☐ Yes	☐ No	Discharge from Eyes	☐ Yes	☐ No	Losing Place While Reading	☐ Yes	☐ No
Watery eyes	☐ Yes	☐ No	Dry Eyes	☐ Yes	☐ No	Night vision problems	☐ Yes	☐ No
Itchy Eyes	☐ Yes	☐ No	Floating Spots	☐ Yes	☐ No	Extreme light sensitivity	☐ Yes	☐ No
Burning Eyes	☐ Yes	☐ No	Excessive Squinting	☐ Yes	☐ No	Other		

MEDICAL HISTORY

Height_____ Weight_____
Do you have any allergies to medications? ☐ No ☐ Yes If yes, please list _____
Do you have any environmental allergies? ☐ No ☐ Yes If yes, please list _____
List all medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies).

_____

List MAJOR injuries, surgeries, and/or hospitalizations you have had:

_____

Do you now or have you ever experienced any problems in the following areas? Please circle all that apply.

Constitutional	**Cardiovascular**	**Ear/Nose/Throat**	**Respiratory**	**Gastrointestinal**	**Genitourinary**	**Musculoskeletal**
Fever Weight loss Weight gain Dizziness Vertigo	High blood pressure High cholesterol Stroke Heart Disease	Allergies/hay fever Sinus congestion Chronic cough Dry throat/mouth	Asthma Chronic Bronchitis Emphysema Cancer COPD	Crohn's IBS Ulcer Digestive difficulties	Genital problem Kidney disorder Bladder disorder	Arthritis Gout Sciatica Fibromyalgia
Integumentary/ Skin	**Neurological**	**Psychiatric**	**Endocrine**	**Hematologic/ Lymphatic**	**Immunologic**	**Other**
Eczema Psoriasis Cancer	Headaches Migraines Multiple Sclerosis Dementia	Depression Anxiety Panic Disorder Bipolar	Type 1 Diabetes Type 2 Diabetes Thyroid dysfunction	Bleeding problems Anemia	Rheumatoid arthritis Lupus	

FAMILY HISTORY

Eye diseases:	☐ Glaucoma ☐Macular degeneration ☐ Cataracts ☐ Retinal disease ☐ Corneal disease ☐ Crossed eyes
Systemic diseases:	☐ Diabetes ☐ High blood pressure ☐ Cancer ☐ Heart disease
Other:	

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