Clinical Research Study Patient Registration and History Form
David L. Wirta, MD

Date: _____

Patient Name: _____

Address: _____

_____
city state zip

E-mail address _____

Phone No. (home) ( ) _____

Phone No. (work) ( ) _____

Mobile No. ( ) _____

Sex: Male Female

Birth date: _____ **Age:**_____ years

Eye Color: Blue Brown Green Hazel Grey

Race: Caucasian Black Asian Hispanic Other:_____
pls.specify

Marital Status: Single Married Divorced Widowed

How were you referred to the Eye Research Foundation?

Dr. Wirta Newspaper Ad _____ Dr. _____
pls specify which paper pls specify name

Patient Social Security No. _____

Name of Primary Care MD: _____

Name of Ophthalmologist: _____ **Last exam date:**_____

In case of emergency, please provide the name of a contact that does not live in your household:

Name: _____ **Relationship:** _____

Home Phone: (**)** _____ **Work Phone: (** **)** _____

MEDICAL HISTORY

Patient Name: _____ **Date:**_____

Do you have asthma: Yes No

Please list any medical conditions and surgeries you have had in the past. Please also include any drug allergies. ***Some examples include asthma and other respiratory problems, diabetes, high blood pressure, arthritis, headaches, heartburn, depression, insomnia, tumors, hypercholesterolemia, heart conditions, stoke, skin conditions, urinary problems, anxiety, hearing loss, nasal allergies, sinus problems, etc.***

Please answer YES or NO to the medication question below and list the medication on the next page.

If you are female, please indicate if you have had a hysterectomy or are post-menopausal.

	Disease/Condition	Start Date	End Date	I / C / R*	Surgery Y/N	Type of Surgery	Date of Surgery	Do you take medicine for this condition? Yes/No
	example: Appendicitis	*month/year*	*month/year*	*R*	*Y*	*appendectomy*	*month/year*	*no*
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								

* I = Intermittent, C = Continuous, R = Resolved

OCULAR HISTORY

Patient Name: _____ **Date:** _____

Do you have glaucoma or ocular hypertension?: **No** **Yes**

If yes, please tell us the month/year you were you first diagnosed? _____
month/year

Please indicate what medication you are currently taking for your glaucoma or ocular hypertension and the date you started it: _____ _____
medication name **date started**

Please list any eye conditions and eye surgeries you have had in the past. Please also include any drug allergies. ***Some examples include dry eye, "lazy eye", retinal detachment, alphagan allergy, lasik, etc.***

	Disease/Condition	Which eye?	Start Date	End Date	I / C / R*	Surgery Y/N	Type of Surgery	Date of Surgery	Do you take medicine for this condition?
	example.: dry eye	*both*	*month/year*	*month/year*	*C*	*No*			*refresh tears*
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

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MEDICINES

Patient Name: _____ **Date:** _____

Please list ANY and ALL medications you take, including over the counter medicines, herbal supplements and vitamins. Please include any medications you indicated you take from the previous page.

	Medication (vitamin or supplement)	Dose	How many times a day do you take it?	What condition do you take this medication for?	Start Date
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					