Eye Center of South Florida
Welcome To Our Office

Name: _____ Today's Date: _____

Full Address: _____ Zip Code: _____

E-mail: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Method of Communication? Text, E-mail, Phone: _____

Ins. Co. / Plan #: _____ Group #: _____ Member Name: _____

Occupation: _____

Birthdate: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Last Optometrist or Ophthalmologist: _____ Last Eye Exam: _____ month _____ year

Primary Care Physician: _____ Phone: _____

How did you hear about us? _____ Reason for today's visit? _____

Medical History

Do you have any allergies to medications? ☐ Yes ☐ No If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies):

_____

_____

_____

List all major injuries, surgeries and/or hospitalization you've had: _____

_____

Check any of the following that you have had: ☐ Reading Difficulty ☐ Crossed Eyes ☐ Lazy Eye ☐ Glaucoma ☐ Retinal Disease ☐ Cataracts ☐ Eye Injury

Are you pregnant and/or nursing? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pari? _____

How many pairs of glasses do you currently use?

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair of contacts? _____

Type of contact lenses? ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ Yes ☐ No

Have you had refractive surgery? ☐ Yes ☐ No

At work: Do you perform fine or close-up work? ☐ Yes ☐ No

Are you outdoors all or part of the time? ☐ Yes ☐ No

Is safety protection a concern at work? ☐ Yes ☐ No

Do you have trouble reading signs when driving at night? ☐ Yes ☐ No

Are you bothered by the glare from: Overhead lighting? ☐ Yes ☐ No

A computer screen? ☐ Yes ☐ No

Oncoming headlights at night? ☐ Yes ☐ No

Are you sensitive in bright sunlight? ☐ Yes ☐ No

What hobbies or recreational sports do you enjoy? _____

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease / Condition	YES	NO	**Relationship To You**
Blindness	☐	☐	
Cataract	☐	☐	
Crossed Eyes	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Retinal Detachment / Disease	☐	☐	
Systematic Disease / Condition			
Arthritis	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Kidney Disease	☐	☐	
Lupus	☐	☐	
Thyroid Disease	☐	☐	
Other _____	☐	☐	

Social History

☐ Yes, I would prefer to discuss my Social History information directly with my doctor (Check Box)

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

_____

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

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 ever been exposed to or infected with: ☐ HIV ☐ Gonorrhea ☐ Hepatitis ☐ Syphilis ☐ No, I have not.

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	YES	NO
Cancer (type)_____	☐	☐
Constitutional		
Fever	☐	☐
Weight Loss / Gain	☐	☐
Constipation	☐	☐
Skin (Integumentary)		
(type)_____	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Parkinson's Disease	☐	☐
Eyes		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision / Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucus Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare / Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye or Lid	☐	☐
Sty or Chalazion	☐	☐
Flashes / Floaters in Vision	☐	☐
Tired Eyes	☐	☐

Additional Comments

SYSTEM	YES	NO
Endocrine		
Diabetes	☐	☐
Cholesterol Elevated	☐	☐
Thyroid / Other Glands	☐	☐
Psychiatric		
Depression	☐	☐
Alzheimer's Disease	☐	☐
Autism	☐	☐
Anxiety	☐	☐
Ear / Nose / Mouth / Throat		
Allergies / Hay Fever	☐	☐
Sinusitis	☐	☐
Hearing Loss	☐	☐
Chronic Cough	☐	☐
Dry Throat / Mouth	☐	☐
Respiratory		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Tuberculosis	☐	☐
Cardiovascular		
Heart Condition	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Cardiovascular Disease	☐	☐
Brain Injury / Stroke	☐	☐

SYSTEM	YES	NO
Gastrointestinal		
Diarrhea	☐	☐
Gastritis	☐	☐
Heartburn	☐	☐
Hepatitis	☐	☐
Genitourinary		
Prostate / Ovarian	☐	☐
Kidney / Bladder	☐	☐
Musculoskeletal		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Back-Pain	☐	☐
Osteoporosis	☐	☐
Lymphatic / Hematologic		
Anemia	☐	☐
Bleeding Disorders	☐	☐
Hodgkin's Disease	☐	☐
Allergic / Immunologic	☐	☐
Autoimmune		
(type)_____	☐	☐

Name: _____

I acknowledge receipt of the Medical Record Privacy Policy (HIPAA).

Date: _____

Signature: _____

_____

Doctor's Signature