

WELCOME BACK TO OUR OFFICE

Today's Date _____

Patient Information

Last _____

First _____ MI _____

Street _____

City _____ State _____

Zip Code _____

Home Phone _____

Work Phone _____

Date of Birth _____ Age _____

Patient's SSN _____ Sex: M F

Employer _____

Occupation _____

Marital Status: single married widowed divorced

Spouse's Name _____

Email Address _____

What is the major purpose of this visit?

Any problems with your current contact lenses or glasses?



Our mission, at Lake Mary Eye Care, is to provide excellence in eye care while maintaining quality, value and dedication to our patients' visual needs. In addition, we will keep our doctors and staff knowledgeable through continuing education to provide the highest level of service to enhance the quality of life in our community. Our doctors and staff strive to show compassion in practice with the highest ethical standards to establish a trusting relationship. This we pledge to our patients.

Insurance Information

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber ID _____

Subscriber Birth Date _____

Do you participate in a flex spending account?

Yes No

Lifestyle Questions

Do you.....(check box if your answer is yes)

- ..work at a computer? How much? ____Hrs/day
- ..think you might benefit from thinner, lighter lenses?
- ..spend time outdoors? How much? ____Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..experience bothersome glare or reflection, particularly when night driving?
- ..have an east/west commute in your daily drive?
- ..want information on Laser Vision Correction surgery?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current prescription eyewear?
- ..have children?
- ..have family members in need of eye care?

Have you ever experienced, been diagnosed or treated for any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Corneal Abrasions |
| <input type="checkbox"/> Crossed eye/Eye turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Flash of light |
| <input type="checkbox"/> Floaters/Spots | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Grittiness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Iritis/Uveitis | <input type="checkbox"/> Itchiness |
| <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Occasional dryness | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Sunlight Sensitivity | <input type="checkbox"/> Tearing |
| <input type="checkbox"/> Trouble seeing at night | |
| <input type="checkbox"/> Other eye disorders _____ | |

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History		
Name of Family Physician _____		
Town _____		
Date of Last Physical Check-up _____		
CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills) _____		

Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, what medications? _____		

Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, please explain _____		
Do you use cigarettes/tobacco, alcohol, or other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been diagnosed or treated for the following health problems?		
	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Patient Eye History	
Date of Last Eye Exam _____	
By Whom? _____	
Have you ever tried contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What kind? _____	
Solutions used _____	
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had vision therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following:	
<input type="checkbox"/> No	<input type="checkbox"/> Yes (Please check boxes)
	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cancer	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____
We may need to instill drops to examine your eyes. These drops may cause temporary light sensitivity and blurred vision.	
Signature _____	

