Welcome to our office

Personal Information: Date: _____________

Name: Last___________________ First _________________ Nickname ______________ DOB___________ Guardian (if minor)______________

Address____ City______________________ State __**FL**_____ Zip _____________

Phone (H)_______________________________ (C)________________________________ (W)_______________________________

Email ____ (May we contact you via email? Y N) (Your email will never be released to a 3rd party.)

How did you hear about our office?: Phonebook Web Search Insurance Listing Personal Referral (name)______________________________

Insurance: VSP VCP EyeMed None Occupation________________________ Hobbies______________________________

I currently wear: Glasses Contacts Neither **This eye examination is for:** Glasses Contacts Other

When was your last exam?_________________________ Previous doctor/optical ______________________________

Briefly state which issues you are visually having____

Patient History: **(In order to serve you better and help speed up the exam process please make sure the following sections are fully completed.)**

	Yes	No	Medication/Treatment
Glaucoma	☐	☐	_________________________
Cataracts	☐	☐	_________________________
Macular Degeneration	☐	☐	_________________________
Other retinal problems	☐	☐	_________________________
Lazy eye or eye turn	☐	☐	_________________________
Eye Surgery	☐	☐	_________________________
Eye infections or injuries	☐	☐	_________________________
Color blindness	☐	☐	_________________________
Light sensitivity	☐	☐	_________________________
Double Vision	☐	☐	_________________________
Flashes or floaters	☐	☐	_________________________

	Yes	No	Medication/Treatment
Diabetes	☐	☐	_________________________
High Blood Pressure	☐	☐	_________________________
High Cholesterol	☐	☐	_________________________
Heart Disease	☐	☐	_________________________
Lung Disease/Asthma	☐	☐	_________________________
Thyroid Disease	☐	☐	_________________________
Arthritis	☐	☐	_________________________
Cancer (type)	☐	☐	_________________________
Frequent Headaches	☐	☐	_________________________
HIV/AIDS	☐	☐	_________________________
Hepatitis	☐	☐	_________________________

Other pertinent history ____

____

List other medications you are taking:____

____

Known drug or environment allergies:____

Family History:

Has anyone in your family had the following? (Please note maternal or paternal grandmother/grandfather) (ie MGM /PGF or PGM/PGF)

	Yes	No	**Family Members**
Glaucoma	☐	☐	___________________________
Macular Degeneration	☐	☐	___________________________
Lazy eye or eye turn	☐	☐	___________________________
Blindness	☐	☐	___________________________
Cataracts	☐	☐	___________________________

	Yes	No	**Family Members**
High Blood Pressure	☐	☐	___________________________
Diabetes	☐	☐	___________________________
Heart Disease	☐	☐	___________________________
Cancer (type)	☐	☐	___________________________

In case of an emergency, whom may we call today? Name______________________ Tel_____________________ Relation____________

Patient/Parent Signature____ Date_________________

THE EYEDOCTORS OF NEW TAMPA

WELCOME BACK TO OUR OFFICE

Personal Information: Date: _____________

Name Changes: ____

Address Changes: ____

Phone Changes/Additions: (hm)_____________________ (cell) ______________________ (wk)________________________

Email Changes/Additions: ____ (Your email will never be released to a 3rd party.)

Insurance Changes: VSP VCP EyeMed None Occupation Changes______________________________

This eye examination is for: Glasses Contacts Other

Did you have your eyes examined anywhere else since your last exam here (including specialists)____

Briefly state which issues you are visually having____

Patient History:

Any new medical conditions? ____

Any medication changes? (added or stopped)(please include vitamins/supliments)____________________________________

____

Any eye infections since your last visit? ____

Other pertinent history ____

____

____

New known drug or environment allergies:____

____

Family History: (Any new developments?): ____

____

In case of an emergency, whom may we call today?

Name__________________________________ Phone_______________________________ Relationship_____________________

Patient/Parent Signature____ **Date**__________________