

Welcome to Lake Nona Eye Care

PATIENTS NAME _____ DOB _____ AGE _____ SEX _____
 STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____
 PHONE (HOME) _____ CELL _____ EMAIL _____
 EMPLOYER (SCHOOL) _____ OCCUPATION(GRADE) _____
 VISION INSURANCE _____ POLICY HOLDER'S SS # _____
 EMERGENCY CONTACT _____ PHONE _____
 WHO CAN WE THANK FOR YOUR REFERRAL _____

OCULAR HISTORY

Approximate date of last eye examination _____ Reason for today's visit _____
 Do you currently wear: Corrective glasses? Y / N Contact lenses? Y / N
 Are you interested in contact lenses? Y / N
 Have you ever had eye surgery or injury? Y / N Explain: _____

GENERAL HEALTH HISTORY: How is your general health _____ Do you have any allergies _____
 If yes, what DRUGS or FOODS are you allergic to _____
 Name of General Physician _____ Phone Number _____

HEALTH INFORMATION (If yes, please check all that apply)

	You	Family		You	Family
Cataracts	___	___	High Blood Pressure	___	___
Glaucoma	___	___	High Cholesterol	___	___
Dry eyes	___	___	Diabetes	___	___
Lazy Eye	___	___	Asthma	___	___
Retinal Detachment	___	___	Cancer	___	___
Macular Degeneration	___	___	Ear/Nose/Throat Disease	___	___
Headaches	___	___	Heart Disease	___	___
Gastrointestinal	___	___	Arthritis	___	___
Stroke	___	___	Nervous System	___	___
Urinary Tract or Bladder	___	___	Mental	___	___
Thyroid	___	___			

Describe _____
 What medications do you take every day _____
 What medications do you take occasionally _____

PAST SURGICAL HISTORY: Please list all past surgeries with approximate dates

SOCIAL HISTORY

Do you use cigarettes/tobacco? Y / N Alcohol? Y / N Other substance(s)? Y / N Are you HIV/AIDS positive? Y / N
 Our doctors believe that most patients should have their eyes examined with the use of eye drops to dilate the pupils.
 Dilated pupils will cause sensitivity to bright light and blurred reading vision for 3-6 hours. Driving may be difficult and should be done with caution. We will gladly provide you with disposable sunglasses, if you do not have a pair.

- _____ I agree to have my eyes dilated today.
- _____ I do not agree to have my eyes dilated.
- _____ I cannot have my eyes dilated today, but will reschedule this procedure at a later date.

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES & HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT

Signature _____ Date: _____ Dr's Initials _____