Family Eye Health MIAMI
MEMBER Vision Source NETWORK

WELCOME TO OUR OFFICE!

Today's Date: ______________________________________

Full Name ____

Address ____

City ___________________ State ______ Zip Code ________

Home Phone ____

Work Phone ____

Cell Phone ____

Social Security # ___________-_____________-___________

Employer (or School) _________________________________

Occupation (or Grade) ________________________________

Spouse (or Parent) Name ______________________________

Spouse (or Parent) Work _______________________________

Date of Birth ____________ Age ______ Gender M F

Email Address ______________________________________

What is the major purpose of the visit?

____

____

Are you planning on purchasing glasses today? Yes __ No __

DO YOU … (check all that apply)

- ☐ Work at a computer?
- ☐ Think you might benefit from thinner, lighter lenses?
- ☐ Have an interest to trial the latest contact lens designs?
- ☐ Spend time outdoors? If so, __________hours/week
- ☐ Have prescription sunglasses?
- ☐ Prefer not to wear your glasses at times?
- ☐ Want information on Laser Vision Correction surgery?
- ☐ Have interest in a non-surgical approach to vision correction?
- ☐ Have more than one pair of current prescription glasses?
- ☐ Have children?
- ☐ Have family members in need of eye care?
- ☐ Wear bifocals? ____ If so, do the lines or head tilting bother you? ____
- ☐ Wear contact lenses? ____ If so, are you satisfied with the vision and comfort? ____

INSURANCE INFORMATION

Vision Insurance _______________________________

Subscriber Name _______________________________

Subscriber SSN ________________________________

Subscriber DOB ________________________________

Primary Medical Insurance ______________________

Subscriber Name _______________________________

Subscriber SSN ________________________________

Subscriber DOB ________________________________

Secondary Medical Insurance ___________________

Subscriber Name _______________________________

Subscriber SSN ________________________________

Subscriber DOB ________________________________

****Please be aware that when the exam is being performed, if a medical diagnosis is found, we may have to use your medical insurance due to the fact that your vision insurance will not cover these additional services****

FAMILY HISTORY

Disease/Condition		Relationship
Blindness	Y N ?	_______________
Cataract	Y N ?	_______________
Corneal Problems	Y N ?	_______________
Crossed/Lazy Eyes	Y N ?	_______________
Glaucoma	Y N ?	_______________
Macular Degeneration	Y N ?	_______________
Retinal Detachment	Y N ?	_______________
Arthritis	Y N ?	_______________
Cancer	Y N ?	_______________
Diabetes	Y N ?	_______________
Heart Disease	Y N ?	_______________
High Blood Pressure	Y N ?	_______________
Kidney Disease	Y N ?	_______________
Lupus	Y N ?	_______________
Thyroid Disease	Y N ?	_______________
Other _____________	Y N ?	_______________

VERY IMPORTANT!

Who may we thank for referring you to our office?

____

If not referred, how did you choose our office for your needs?

- ☐ Another doctor
- ☐ Insurance list
- ☐ Signage/Location
- ☐ Other ___________

- ☐ Social Media
- ☐ Google
- ☐ Yelp
- ☐ Website

____

EYE HEALTH HISTORY

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

Date of last eye exam ____________________________________

By Whom? ____

Do you wear glasses? Y N

Have you ever tried contact lenses? Y N

Do you currently wear contact lenses? Y N

What Kind? ____

Solution used ____

Would you prefer clear lenses or colored lenses? _____________

If you wear contact lenses are you satisfied with the vision/comfort? Y N

Do you have a backup pair of eyeglasses? Y N

Have you ever been diagnosed or treated for the following:

- ☐ Cataracts
- ☐ Corneal Abrasion
- ☐ Eye Infection
- ☐ Eye Injury
- ☐ Glaucoma
- ☐ Iritis
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Other eye disorders

Do you experience or have you ever experienced:

- ☐ Blurry vision
- ☐ Burning
- ☐ Tearing/watering
- ☐ Headaches
- ☐ Double Vision
- ☐ Occasional dryness
- ☐ Redness
- ☐ Loss of Vision
- ☐ Loss of Side Vision
- ☐ Tired Eyes
- ☐ Eye pain/soreness
- ☐ Chronic infection of eye or lid
- ☐ Flashes of light
- ☐ Floaters/spots
- ☐ Grittiness
- ☐ Itchiness
- ☐ Glare/Light Sensitivity
- ☐ Crossed/Lazy Eyes
- ☐ Trouble seeing at night
- ☐ Distorted vision/halos
- ☐ Mucous discharge
- ☐ Foreign Body Sensation
- ☐ Stye or Chalazion

SOCIAL HISTORY

This information is kept strictly confidential; however, you may discuss this portion directly with the doctor if you prefer

☐ Yes, I would prefer to discuss my social history information directly with my doctor

Do you use tobacco products? Y N

--If yes, type/amount/how long? _________________

Do you drink alcohol? Y N

--If yes, type/amount/how long? _________________

Do you use illegal drugs? Y N

--If yes, type/amount/how long? _________________

Have you ever been exposed to or infected with:

- ☐ Gonorrhea
- ☐ Hepatitis
- ☐ HIV
- ☐ Syphilis

MEDICAL HISTORY

Name of Family Physician _____________________________

Date of Late Physical Exam ____________________________

Do you have any allergies to medications? Y N

If yes, please explain

____

____

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

____

____

____

Are you currently pregnant or nursing? Y N

List all major injuries, surgeries, and/or hospitalizations you have had ______________________________________

____

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

Constitutional

Fever, weight loss/gain Y N ?

Integumentary (Skin) Y N ?

Neurological

Headache/Migraines Y N ?

Stroke Y N ?

Seizures Y N ?

Endocrine

Thyroid/Other Glands Y N ?

Ears, Nose, Mouth, Throat

Allergies/Sinus Y N ?

Chronic Cough Y N ?

Dry Throat/Mouth Y N ?

Respiratory

Asthma Y N ?

Chronic Bronchitis Y N ?

Emphysema Y N ?

Vascular/Cardiovascular

Diabetes Y N ?

Heart Pain Y N ?

High Blood Pressure Y N ?

Vascular Disease Y N ?

Gastrointestinal

Crohn's Disease Y N ?

Acid Reflux/IBS Y N ?

Genitourinary

Genitals/Kidney/Bladder Y N ?

Bones/Joints/Muscles

Rheumatoid Arthritis Y N ?

Muscle pain/Joint Pain Y N ?

Lymphatic/Hematologic

Anemia Y N ?

Bleeding Problems Y N ?

****I had the opportunity to review your Privacy Policy, effective 07/01/2017****

________________________________ ____________

Patient Signature **Date**