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

Dr. Ward believes 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_____