Central FloridaEyes

EMY FELICIANO, O.D.

Welcome to our office. Please take a moment to complete this form so we may help care for your eye health needs.

FIRST: _____ LAST NAME: _____
MIDDLE: ____

ADDRESS:
_____APT. #_____

CITY: _____ STATE: _____ ZIP:
_____

PATIENTS DATE OF BIRTH: _____/_____/_____ AGE: _____ GENDER: [ ] MALE [ ] FEMALE

TELEPHONE NUMBER: _____ TELEPHONE NUMBER:
_____

OCCUPATION: _____
HOBBIES_____

EMAIL:
_____

NAME OF **VISION INSURANCE** COMPANY: _____ID NUMBER:
_____

CARD HOLDER: _____SOCIAL SECURITY NUMBER:
_____

NAME OF **MEDICAL INSURANCE** COMPANY: _____ ID NUMBER:
_____

CARD HOLDER: _____SOCIAL SECURITY NUMBER:
_____

TODAY'S DATE: ____/____/____

HOW DID YOU HEAR ABOUT US?

- € INSURANCE
- € NEWSPAPER
- € INTERNET
- € LOCATION

REFERRED BY:

- € FRIEND
- € PRIMARY CARE DOCTOR
- € SELF

DR:_____

WHO MAY WE THANK FOR REFFERING YOU?

NAME: _____

TEL: _____

EMERGENCY CONTACT: _____ TELEPHONE NUMBER:
_____

DO YOU CURRENTLY

- € WEAR CONTACT LENSES?
- € TRIED CONTACT LENSES?
- € WEAR GLASSES?

HAVE YOU HAD? PLEASE DESCRIBE

- € CATARACT SURGERY? __/__/__
- € EYE MUSCLE SURGERY__/__/__
- € RETINAL SURGERY __/__/__
- € LASIK SURGERY __/__/__
- € LASIK CONSULT __/__/__
- € EYE INJURY __/__/__
- € FOREIGN BODY __/__/__
- € EYE TRAUMA __/__/__
- € CORNEAL SCAR __/__/__
- € OTHER: _____ __/__/__

ARE YOU OR HAVE YOU EVER EXPIRIENCED ANY OF THE FOLLOWING:

- € Blurred Vision
- € Burning
- € Double Vision
- € Dryness
- € Excessive Tearing/ Watering
- € Eye or Eyelid Infection
- € Frequent Headaches/ Migraines
- € Flashes of light
- € Floaters
- € Glare / Light Sensitivity
- € Itching
- € Mucous Discharge
- € Redness
- € Sandy or gritty Feeling
- € Sudden loss of side vision
- € Sudden loss of vision
- € Night driving difficulty
- € Other:_____

PREGNANCY

- € ARE YOU CURRENTLY? **YES** **NO**

REASON FOR VISIT:

- € REGULAR EYE EXAM
- € EMERGENCY
- € CONTACT LENS EXAM/FIT
- € LASER CONSULTATION
- € DIABETIC EYE EXAM
- € GLAUCOMA EVALUATION

OTHER_____

OCULAR HISTORY:	**SELF**	**FAMILY**
Amblyopia/ Lazy eyes	___	___
Blindness	___	___
Cataracts	___	___
Color Blindness	___	___
Crossed/ Turned eyes	___	___
Diabetic Retinopathy	___	___
Dry eyes	___	

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CURRENT MEDICATIONS/ VITAMINS:

_____
__
_____
__
_____
__
_____
__
_____
__
_____
__

ALLERGIES:

_____
_____
__
_____
__

€ HOW MANY PREGNANCIES?
_____

Several procedures are required to examine the health of your eye and determine treatment and/or the prescription for your eyewear. Dilating drops allow the Doctor to examine the structures inside of the eye. These drops may result in but not limited to light sensitivity, hazy vision and difficulty focusing at near, for duration of (4) to (10) hours. Please exercise caution while driving, operating equipment, or reading during the duration of these effects. I acknowledge the importance of dilating drops, as well as, understand the effects on my vision and the use of dilating eye drops.

[ ] ACCEPT [ ] DECLINE

INITIAL: _____

PATIENT/GUARDIAN SIGNARUE:
_____**DATE:**_____

PRINTED NAME: _____ _____**RELATIONSHIP:**
_____

___
Glaucoma ___
___
Herpes Simplex Keratitis ___
___
Keratoconus ___
___
Macular Degeneration ___
___
Retinal Detachment ___
___
Other vision disorders:_____

MEDICAL HISTORY: SELF FAMILY

Cholesterol ___
___
Cardiovascular (Heart) Disease ___
___
Diabetes ___
___
High blood pressure ___
___
Neurological ___
___
(Multiple sclerosis) ___
___
Respiratory ___
___
(Asthma, Bronchitis, Emphysema)
Thyroid ___
___
Tuberculosis ___
___
Other:_____
___