The Eye Institute Of West Florida

Patient Information

PATIENT INFORMATION

TODAYS DATE: _____

FIRST: _____ MIDDLE: _____ LAST: _____

ADDRESS: _____

ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL ADDRESS : _____

PREFERRED METHOD OF CONTACT: ☐ HOME ☐ CELL ☐ EMAIL ☐ TEXT

SOCIAL SECURITY: _____ DATE OF BIRTH: _____ SEX: _____

MARITAL STATUS: _____ RACE: _____ ETHNICITY: _____

PRIMARY LANGUAGE: _____ PRIMARY CARE PHYSICIAN: _____

HOW DID YOU HEAR ABOUT US? _____

IF YOU WERE REFERRED BY A DOCTOR, PLEASE LIST:

NAME: _____ LOCATION: _____

EMPLOYMENT INFORMATION

OCCUPATION: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT INFORMATION

FIRST: _____ LAST: _____

HOME PHONE: _____ WORK PHONE: _____

RELATIONSHIP: _____

POWER OF ATTORNEY or MEDICAL POWER OF ATTORNEY

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ PHONE: _____ SOCIAL SECURITY: _____

RELATIONSHIP TO PATIENT: _____

Allergies and Medications

TODAYS DATE: _____

NAME: _____ **DATE OF BIRTH:** _____

Allergies: _____

_____

_____

Please bring a list of all current medications and dosages with you to your appointment.

Medications

All Medications	Strength	Frequency	Last Drop	Date

Medical History

TODAYS DATE: _____

PAST EYE HISTORY

DO YOU HAVE:

	NO	(Y)RIGHT EYE	(Y) LEFT EYE	COMMENTS
Distance Glasses	☐	☐	☐	_____
Reading Glasses	☐	☐	☐	_____
Bifocals	☐	☐	☐	_____
Contact Lenses	☐	☐	☐	_____
Lazy Eye	☐	☐	☐	_____
Vision Loss	☐	☐	☐	_____
Blurry Vision	☐	☐	☐	_____
Eye Pain	☐	☐	☐	_____
Redness	☐	☐	☐	_____
Itching	☐	☐	☐	_____
Discharge	☐	☐	☐	_____
Floaters	☐	☐	☐	_____
Flashes of Light	☐	☐	☐	_____

HAVE YOU HAD OR BEEN TOLD YOU HAVE:

	NO	(Y)RIGHT EYE	(Y) LEFT EYE	COMMENTS
Cataracts	☐	☐	☐	_____
Eye Surgery - Cataracts	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Retinal Disease	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Eye Surgery - Glaucoma	☐	☐	☐	_____
Eye Surgery - Other	☐	☐	☐	_____
Other	☐	☐	☐	_____

DO YOU RELY ON TRANSPORTATION SERVICES (DART, CARE RIDE, etc)

YES ☐ **NO** ☐

LIVING STATUS:

	YES	NO
Live alone	☐	☐
Assisted Living Facility	☐	☐

ALCOHOL USAGE:

Denies	☐	Occasionally	☐	2 per day	☐
Socially	☐	1 per day	☐	+ 2 daily	☐

TOBACCO USE:

☐ Current tobacco non-user
☐ Current tobacco smoker
☐ Current tobacco smokeless tobacco user (eg. chew, snuff)

IF SMOKER, SMOKING HISTORY IS

PACKS PER DAY	LENGTH	QUIT
☐ < 1 pack per day	☐ for < 5 years	☐ quit < 1 year ago
☐ 1 pack per day	☐ for 5-10 years	☐ quit 1-5 years ago
☐ 2 packs per day	☐ for 10-15 years	☐ quit 5-10 years ago
☐ 3 packs per day	☐ for 15-20 years	☐ quit 10-15 years ago
☐ 4 packs per day	☐ for 20-25 years	☐ quit 15-20 years ago
☐ 4+ packs per day	☐ for > 25 years	☐ quit > 20 years ago

DO YOU HAVE ADVANCED DIRECTIVES (LIVING WILL)?

YES ☐ **NO** ☐

HOBBIES

_____

_____

_____

GENERAL MEDICAL HISTORY

	YES	NOTES
Patient denies any history of medical conditions/diseases	☐	

CARDIOVASCULAR

Congestive heart failure	☐	
Coronary artery disease	☐	
Elevated cholesterol	☐	
Heart attack	☐	
Heart valve disease	☐	
Hypertension	☐	
Pacemaker	☐	
Other cardiovascular	☐	

DERMATOLOGIC

Keloid formation	☐	
Shingles	☐	
Skin cancer	☐	
Other dermatologic	☐	

GASTROINTESTINAL

Colon cancer	☐	
Crohn's	☐	
GI bleeding	☐	
Ulcerative colitis	☐	
Other gastrointestinal	☐	

	YES	NOTES
GENITOURINARY		
Enlarged prostate	☐	
Kidney disease	☐	
Other genitourinary	☐	
HEMATOLOGIC		
Anemia	☐	
Bleeding disorder	☐	
Blood clots	☐	
Leukemia	☐	
Sickle Cell	☐	
Other hematologic	☐	
INFECTIOUS DISEASE		
Hepatits C	☐	
HIV	☐	
MRSA	☐	
Tuberculosis	☐	
Other infectious disease	☐	
METABOLIC/ENDOCRINE		
Diabetes, Type I	☐	
Diabetes, Type II	☐	
Thyroid disease	☐	
Other metabolic/endocrine	☐	
MUSCULOSKELETAL		
Gout	☐	
Osteoarthritis	☐	
Rheumatoid arthritis	☐	
Other musculoskeletal	☐	

	YES	NOTES
NEUROLOGIC		
Dementia	☐	
Multiple sclerosis	☐	
Seizures	☐	
Stroke	☐	
Other neurologic	☐	
PULMONARY		
Asthma	☐	
COPD	☐	
Lung cancer	☐	
Sarcoid	☐	
Sleep apnea	☐	
Other lung disease	☐	
PSYCHIATRIC		
Anxiety	☐	
Bipolar	☐	
Depression	☐	
Schizophrenia	☐	
Other psychiatric	☐	
WOMENS HEALTH		
Breast cancer	☐	
Ovarian/cervical cancer	☐	
Other women's health	☐	

PAST SURGICAL HISTORY

	SURGERY DETAILS	DATE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

FAMILY HISTORY

	Father	Mother	Sibling	COMMENTS
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment	☐	☐	☐	
Blindness	☐	☐	☐	
Parkinson's	☐	☐	☐	
Alzheimer's	☐	☐	☐	
Unknown	☐	☐	☐	
Other	☐	☐	☐	
No significant family history	☐	☐	☐	