703 N Main St. Kissimmee, FL 34744 Tel: (407) 350-4342

GENERAL INFORMATION

Full Name: Preferred name:

Address: City: State: Zip code:

Cell phone: Authorize to communicate by text messages: Yes or No *(please circle)*

Home phone: Work phone:

Email:

Social Security Number: Date of Birth:

Sex: Male | Female *(please circle)*

Employer: Occupation:

Marital Status: *married* | *single* | *divorced* | *legally separated* | *widowed (please circle)*

Language: Race: Ethnicity: Hispanic | Non-Hispanic *(please circle)*

Emergency Contact Person: Phone Number:

If you wish to authorize some one to pick up your glasses/contacts/prescription on your behalf, please provide their information below:

1. ______________________________ Relationship to patient: ______________________
2. ______________________________ Relationship to patient: ______________________
3. ______________________________ Relationship to patient: ______________________

Please sign your name: ___________________________________ Date: ____________________

Please print your name: ___________________________________

703 N Main St. Kissimmee, FL 34744 Tel: (407) 350-4342

EYE HISTORY

Date of Last Eye Exam:

Currently Wear: Glasses | Contacts | Both | None

Reason for Today's Visit:

Have you or a family member experienced, or been treated for, any of the following? *Circle all that apply*

Cataracts	*yes*	*no*	*family*
Crossed Eyes	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or PRK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macula Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have experienced, any of the following? *Check all that apply*

- ☐ Blurry Vision *Distance | Near | Both*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you ro a family member experienced, or been treated for, any of the following? *Circle all that apply*

AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*famiily*
Arthritis	*yes*	*no*	*familly*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose, Throat	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	Yes	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorders	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications
(prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke? Yes | No **Have you ever smoke? Yes | No**

Sign here: ____ **Date:** _______________________