THE EYE INSTITUTE OF WEST FLORIDA
Better Vision~Our Specialty

Patient Information

PLEASE PRINT

Account #: _____

Date: _____ **First Name:** _____ **Last Name:** _____ **M.I.**_____

SSN: _____ **D.O.B.:** _____ **Sex:** _____ **Race:** _____

Ethnicity: _____ **Marital Status:** _____ **Primary Language:** _____

Address:

_____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Preferred Method of Contact: (circle one) Home Cell Text Email

Email address_____

Primary Care Physician: _____

If referred by a doctor, please list:

Name: _____**Location:** _____

Employment Information:

Occupation: _____

Address: _____

City: _____ **State:** _____

Emergency Contact Information:

Name: _____

Home Phone: _____**Work Phone:** _____

Relationship: _____

***** If you have a Power of Attorney or Medical Power of Attorney, please give a notarized copy to the front desk.**

Patient Information

Allergies: (specify drug reaction)

_____

_____

Medications/Dose/Frequency:

_____
_____
_____
_____

Medical History: (include all hospitalizations, chronic health problems, major illnesses)

_____
_____
_____
_____

Surgical History: (list all past surgeries and dates):

_____
_____
_____

Past Ocular History: (list all past EYE surgeries, diseases and treatments)

_____
_____
_____

_____

Have you received a flu shot within the last year? _____ Yes _____ No

If yes, what date: _____

Social History: (tobacco, alcohol, drug use)

Do you currently smoke cigarettes? _____Yes _____No How many packs _____

Years _____ Quit Date: _____

Do you currently consume alcohol? _____Yes _____ No Amount per day? _____

Family History:

Cancer	Y	N	If yes; Father, Mother, Sibling (circle)
Diabetes	Y	N	If yes; Father, Mother, Sibling (circle)
Heart Disease	Y	N	If yes; Father, Mother, Sibling (circle)
High Blood Pressure	Y	N	If yes; Father, Mother, Sibling (circle)
Glaucoma	Y	N	If yes; Father, Mother, Sibling (circle)
Macular Degeneration	Y	N	If yes; Father, Mother, Sibling (circle)
Retinal Detachment	Y	N	If yes; Father, Mother, Sibling (circle)
Blindness	Y	N	If yes; Father, Mother, Sibling (circle)
Parkinson's	Y	N	If yes; Father, Mother, Sibling (circle)
Alzheimer's	Y	N	If yes; Father, Mother, Sibling (circle)
Unknown	Y		
Other	Y	N	explain:_____
No Significant Family History		N	

GENERAL MEDICAL HISTORY

Patient denies any history of medical conditions/diseases Yes ___

Current Weight:_____

Review of systems: (check any and all that apply)

Cardiovascular

Congestive Heart
Coronary Artery Disease
High Cholesterol
Heart Attack
Heart Valve Disease
Hypertension
Pacemaker

Dermatologic

Keloid Formation
Shingles
Skin Cancer
Other

Gastrointestinal

Colon Cancer
GI Bleeding
Ulcerative Colitis
Other

Genitourinary

Enlarged Prostate
Kidney Disease
Other

Hematologic

Anemia
Bleeding Disorder
Blood Clots
Leukemia
Sickle Cell
Other

Infectious Disease

Hepatitis C
HIV
MRSA
Tuberculosis
Other

Metabolic/Endocrine

Type I Diabetes
Type II Diabetes
Thyroid Disease
Other

Musculoskeletal

Gout
Osteoarthritis
Rheumatoid Arthritis
Other

Neurologic

Dementia
Multiple Sclerosis
Seizures
Stroke
Other

Pulmonary

Asthma
COPD
Lung Cancer
Sarcoid
Sleep Apnea
Other

Psychiatric

Anxiety
Bipolar
Depression
Schizophrenia
Other

Women's Health

Breast Cancer
Ovarian/cervical Cancer
Other Women's Health

COMMENTS: