

Lantana Eyecare

Welcome to Our Office

Date _____
Last Name _____ First Name _____ MI _____
Address _____
City _____ State _____ Zip _____
Cell Phone _____ Home Phone _____
Date of Birth _____ Occupation _____ Email _____
Emergency Contact Name _____ Phone Number _____
Date of Last Eye Exam _____ Referred By _____
Primary Vision Coverage _____
Policy Holder's Name _____
Policy Holder's SS# _____ Policy Holder's DOB _____

Medical Information

How is your general health? _____

Do you take any medications for any of these symptoms? (Please circle yes or no.)

Gastro intestinal	Y/N	Nervous	Y/N	Endocrine (glands)	Y/N
Ears/Nose/Throat	Y/N	Urinary	Y/N	Blood/Lymph	Y/N
Cardiovascular	Y/N	Muscles/Bones	Y/N	Allergic/Immunologic	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Headaches	Y/N
High Blood Pressure	Y/N	Eyes	Y/N	Mental	Y/N

Please explain _____

Diabetes Y/N _____ Type _____ Date of diagnosis _____

Allergies to medication Y/N Which? _____ Reactions? _____

Other health problems _____

Current medication(s) _____

Have you had any operations Y/N Kind? _____ When? _____

Name of family doctor and/or primary care physician _____

Date of last visit Date your blood pressure was last checked _____

Family History

High blood pressure	Y/N	Relation _____	Macular degeneration	Y/N	Relation _____
Diabetes	Y/N	Relation _____	Retinal detachment	Y/N	Relation _____
Glaucoma	Y/N	Relation _____	Cataracts	Y/N	Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Y/N What kind? _____

Have you had any eye operations? Y/N Type _____

Have you had an eye injury? Y/N Kind _____

Do you have glaucoma? Y/N Cataracts? Y/N Dry Eye? Y/N

Macular degeneration? Y/N Retinal Detachment? Y/N Blurred vision? Y/N

Do you wear glasses? Y/N Contact lenses? Y/N Type _____

Additional Information _____

Yearly Update

Reviewed by _____ No changes Date _____

Reviewed by _____ No changes Date _____

Reviewed by _____ No changes Date _____