BOCA FAMILY EYE CARE
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www.BocaFamilyEye.com

Welcome To Our Office

Personal Information: Date_____ Time _____

Name_____ Nickname_____ D.O.B. _____ Age_____
Address _____ City_____
State _____ Zip _____ Parent Name (If Minor) _____
Phone (H) _____ (C) _____ (W) _____
Email Address _____
Occupation _____Medical Insurance_____ Vision Insurances_____ _____
I currently wear: Glasses Contacts None
This eye examination is for: Glasses Contacts Other
When was your last exam? _____ Previous doctor/ optical _____
Physician _____
Reason for your visit today _____
How did you hear about us? Website/Internet _____ Friend/Family _____ Drive-by _____ Other _____

Patient History:

Do you have or have you ever had the following?

	Yes	No	Meds/Treatment		Yes	No	Meds/Treatment
Glaucoma	Y	N	_____	High Blood Pressure	Y	N	_____
Cataracts	Y	N	_____	High Cholesterol	Y	N	_____
Macular degeneration	Y	N	_____	Heart Disease	Y	N	_____
Other retinal problems	Y	N	_____	Lung Disease / Asthma	Y	N	_____
Lazy eye or eye turn	Y	N	_____	Thyroid Disease	Y	N	_____
Eye surgery	Y	N	_____	Arthritis	Y	N	_____
Eye infections or injuries	Y	N	_____	Cancer	Y	N	_____
Color blindness	Y	N	_____	Frequent Headaches	Y	N	_____
Light sensitivity	Y	N	_____	HIV / AIDS	Y	N	_____
Double vision	Y	N	_____	Hepatitis	Y	N	_____
Flashes or floaters	Y	N	_____	Pregnant (Currently)	Y	N	_____
Diabetes	Y	N	_____				

Do you currently smoke? Y / N Are you a previous smoker? Y / N
Other pertinent history _____
List other medications, vitamins, and/or herbal supplements you are taking:_____
_____
Known drug or environmental allergies: _____

Family History:

Has anyone in your family had the following?

	Yes	No		Yes	No
Glaucoma	Y	N	High Blood Pressure	Y	N
Macular Degeneration	Y	N	Diabetes	Y	N
Lazy eye or eye turn	Y	N	Heart Disease	Y	N
Blindness	Y	N	Cancer	Y	N