GULFCOAST EYE CENTER
Comprehensive Eye Care • Contact Lenses
Diagnosis and Treatment of Ocular Disease

Dr. Steven Bovio
Dr. Cameron Jones
Board Certified Optometric Physician
Member American Optometric Assoc.

PATIENT INFORMATION

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____
Social Security Number: _____
Medical Insurance: _____
Vision Insurance _____
Relationship to Insured: _____
Secondary Insurance: _____

Home Phone: _____
Cellular Phone: _____
E-Mail Address: _____
Primary Care Doctor: _____
Pharmacy: _____
How did you find us? _____

LANGUAGE: _____ RACE: _____ ETHNICITY: _____

PATIENT MEDICAL HISTORY

Please indicate below which conditions you or a family member have. (Parents, Grandparents or Siblings)

	Patient		Explain	**Family Member**		Relationship
Arthritis	Y	N		Y	N	
Blindness	Y	N		Y	N	
Cancer	Y	N		Y	N	
Cataract	Y	N		Y	N	
Crossed Eye	Y	N		Y	N	
Diabetes	Y	N		Y	N	
Drooping Eyelid	Y	N		Y	N	
Eye Infections	Y	N		Y	N	
Eye Injury	Y	N		Y	N	
Glaucoma	Y	N		Y	N	
Heart Disease	Y	N		Y	N	
High Blood Pressure	Y	N		Y	N	
Kidney Disease	Y	N		Y	N	
Lazy Eye	Y	N		Y	N	
Lupus	Y	N		Y	N	
Macular Degeneration	Y	N		Y	N	
Retinal Detachment/ Disease	Y	N		Y	N	
Thyroid Disease	Y	N		Y	N	
Other	Y	N		Y	N	

Please list all medications you are currently taking. Please include prescription medications, oral contraceptives, over the counter medications, and vitamins:

_____

_____

Please list all medications you are allergic to, including reaction:

_____

_____

Please describe any major illnesses, surgeries, or hospitalizations you have had including the approximate date:

_____

_____

Are you currently pregnant or nursing? _____
Do you currently wear glasses? _____ If yes, how old are your lenses? _____
Do you currently wear contacts? _____ If yes, how old are your contacts? _____
What type of contacts do you wear? _____ Are they comfortable? _____
Do you sleep with your contacts in? _____ If yes, how many nights in a row? _____
Do you drive? _____ Please indicate any vision problems you experience while driving. _____
Do you smoke? _____ Do you drink? _____ If yes, how often? _____

**********PLEASE SEE BACK SIDE**********

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REVIEW OF SYMPTOMS

Please indicate below any of the problems you are currently experiencing or have experienced in the past.

NEUROLOGICAL:		
Headaches	Y	N
Migraines	Y	N
Seizures	Y	N
EYES:		
Eye pain or soreness	Y	N
Blurred Vision	Y	N
Distorted Vision/ Halos	Y	N
Loss of Vision	Y	N
Double Vision	Y	N
Flashers/ Floaters in Vision	Y	N
Mucous Discharge	Y	N
Glare/ Light Sensitivity	Y	N
Excessive Tearing/ Watering	Y	N
Redness	Y	N
Dryness	Y	N
Burning	Y	N
Itching	Y	N
Styes	Y	N
Foreign Body Sensation	Y	N
Tired Eyes	Y	N
Chronic Infection of the Eye or Lid	Y	N
Sandy or Gritty Feeling	Y	N
EARS, NOSE, THROAT, MOUTH:		
Sinus Congestion	Y	N
Chronic Cough	Y	N
Dry Throat/ Mouth	Y	N
Runny Nose	Y	N
Post Nasal Drip	Y	N
Allergies/ Hay Fever	Y	N
SKIN:		
Melanoma	Y	N
VASCULAR/ CARDIOVASCULAR:		
Vascular Disease	Y	N
High Blood Pressure	Y	N
Heart Pain	Y	N
Diabetes	Y	N
GASTROINTESTINAL:		
Diarrhea	Y	N
Constipation	Y	N
LYMPHATIC:		
Anemia	Y	N
Bleeding Problems	Y	N
BONES/ JOINTS/ MUSCLES:		
Muscle Pain	Y	N
Joint Pain	Y	N
Rheumatoid Arthritis	Y	N
ENDOCRINE		
Thyroid	Y	N
ALLERGIC/ IMMUOLOGICAL	Y	N
PSYCHIATRIC	Y	N

Patient Signature: _____ Date: _____ Doctor Signature: _____