**Fier Eye Care & Surgery Center**
**514 NW Prima Vista Blvd.**
**Port St. Lucie, Florida 34983**
**Phone: (772) 878-3437**
**Fax: (772) 878-1298**

FIER
EYE CARE & SURGERY CENTER
Sincere Compassion
Unmatched Experience
Cutting Edge Technology

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Welcome to our practice. We are very pleased that you have selected us for your health care needs. We look forward to meeting you and providing you with personal and quality care. We pride ourselves on trying to make your medical care and treatment a pleasant experience.

Please fill out the enclosed forms, checking that all sections are completed, and bring them with you to your visit. Please make sure to bring your current glasses and contact lenses with you to your appointment, as well as all of your eye medications, in a bag. If you have any questions, please do not hesitate to contact us at (772)878-3437 so that we may assist you.

Thank you for choosing Fier Eye Care & Surgery Ctr(P) to take care of your ocular health.

We look forward to seeing you.

## Directions To the Port St. Lucie Office

*Our office is located between Bayshore Blvd and Airoso Blvd, on the south side of Prima Vista Blvd*

**From the SOUTH (traveling NORTH on US1):** Make a LEFT onto Prima Vista Blvd, approximately 4 miles. You must make a U-Turn at Friar Street and come back east ¼ mile to the opening of the parking lot.

**From the NORTH (traveling SOUTH on US1):** Make a RIGHT onto Prima Vista Blvd, approximately 4 miles. You must make a U-Turn at Friar Street and come back east ¼ mile to the opening of the parking lot.

**FROM I-95:** *(St. Lucie West Blvd becomes Prima Vista Blvd and you cross Bayshore Blvd)* Take EXIT 121, which is St. Lucie West Blvd. Head EAST 3 miles (you will cross over the turnpike). After you pass the Bayshore/ Prima Vista intersection, you will travel .6 of a mile and the parking lot entrance will be on the RIGHT.

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# Patient Registration

## Please review, make necessary changes and supply any missing information.

| | | | | | |
|---|---|---|---|---|---|
| **Patient Name** | | | | **Salutation** | |
| **Date of Birth** | | **Age** | | | |
| **Gender** | | | | **SS #** | |
| **Address** | | | | | |

****Do you have a secondary address? □ YES or □ NO**
**If yes, please write it on the back of this paper.**

| **Communication** | | | | | |
|---|---|---|---|---|---|
| **Preference** | | | | | |
| **Home Phone #** | | **Work Phone #** | | **Extension** | |
| **Cell Phone #** | | **Email** | | | |
| **Please Check: I give permission to leave voicemail on:** | ☐ Home Phone<br>☐ Cell Phone<br>☐ Work Phone<br><br>☐ No Voicemails | **Please Check:** | ☐ I understand that email is not a secured medium for transmitting personal health information. | | |

| **Information** | | | |
|---|---|---|---|
| **Primary Language (Please circle)** | English ☐ Spanish ☐<br>French ☐ Italian ☐ Other: ☐ | **Marital Status** | Single ☐ Married ☐ Widowed ☐<br>Divorced ☐ Other: ☐ |
| **Race- (Please circle)** | American Indian ☐ Asian ☐<br>African American ☐<br>Native Hawaiian other Pacific Islander<br>White ☐ Other Race ☐ | **Ethnicity (Please circle)** | Non-Hispanic or Latino ☐<br><br>Hispanic or Latino ☐ |
| **Primary Care Physician:** | | **Who were you referred by?** | |

| **Account Responsible** | | | | | |
|---|---|---|---|---|---|
| **Responsible** | | | | **Salutation** | |
| **Relationship** | | | | **SS #** | |
| **Address** | | | | | |
| **Home Phone #** | | **Work Phone #** | | **Extension** | |
| **Email** | | | | | |
| | | | | | |

| **Primary Insurance** | | | |
|---|---|---|---|
| **Name** | | **Group Name** | |

| Primary Insurance | | | |
|---|---|---|---|
| **ID #** | | **Group #** | |
| **Address** | | | |
| **Insured** | | **Date of Birth** | |
| **Secondary Insurance** | | | |
| **Name** | | **Group Name** | |
| **ID #** | | **Group #** | |
| **Address** | | | |
| **Insured** | | **Date of Birth** | |

| Emergency Contact | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Sal** | **First** | **M** | **Last** | **Relation** | **Home#** | **Cell#** | **Permission to release personal health information** |
| | | | | | | | ☐ Yes<br>☐ No |

| Other Contacts | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Sal** | **First** | **M** | **Last** | **Relation** | **Home#** | **Cell#** | **Permission to release personal health information:** |
| | | | | | | | ☐ Yes<br>☐ No |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## Patient Health History

**Please review, make necessary changes and supply any missing information.** **Date:**

| Review Of Systems | |
|---|---|
| **Please CHECK any symptoms that you are experiencing** | |
| **General** | ☐ Appetite Changes, ☐ Chills, ☐ Fatigue, ☐ Fever, ☐ Light Headedness, ☐ Weakness, ☐ Weight Gain, ☐ Weight Loss |
| **Cardiovascular** | ☐ Tightness, ☐ Chest Pain, ☐ Palpitations, ☐ Shortness of Breath, ☐ Swelling Hands/ Feet, ☐ Sudden Awakening From Sleep with Shortness of Breath |
| **Ears, Nose, Mouth, Throat** | ☐ Ear Drainage, ☐ Hay Fever, ☐ Hoarseness, ☐ Sore Tongue, ☐ Thrush, ☐ Non-Healing Sores, ☐ Dentures, ☐ Dizziness, ☐ Earaches, ☐ Hearing Loss, ☐ Nose Bleeds, ☐ Sinus Pain, ☐ Sore Throat, ☐ Stuffy Nose |
| **Respiratory / Lungs** | ☐ Cough, ☐ Shortness of Breath, ☐ Sputum, ☐ Wheezing, ☐ Coughing up Blood, ☐ Painful Breathing |
| **Stomach / Intestines** | ☐ Change in Appetite, ☐ Constipation, ☐ Diarrhea, ☐ Difficulty Swallowing, ☐ Change in Bowel Movements, ☐ Heartburn, ☐ Jaundice, ☐ Nausea |

| Review Of Systems<br>Please CHECK any symptoms that you are experiencing | |
|---|---|
| **Urinary / Reproductive:** | ☐ Burning/Pain ☐ Blood in Urine ☐ Change in Urinary Strength ☐ Change in Urine Color ☐ Frequent Urination ☐ Incontinence |
| **Bones / Joints / Muscles:** | ☐ Stiffness ☐ Swelling of Joints ☐ Trauma ☐ Back Pain ☐ Joint Pain ☐ Muscle Pain ☐ Neck Pain |
| **Skin / Hair / Nails** | ☐ Changes in Color/ Pigmentation ☐ Changes in Nail/ Hair ☐ Dryness ☐ Itching ☐ Lumps ☐ Skin Rashes |
| **Neurological** | ☐ Headaches ☐ Head Injury ☐ Numbness ☐ Tingling ☐ Tremor ☐ Weakness ☐ Dizziness |
| **Psychiatric** | ☐ Memory Loss ☐ Anxiety ☐ Depression ☐ Nervousness |
| **Endocrine / Hormonal** | ☐ Sweating ☐ Frequent Urination ☐ Thirst ☐ Change in Appetite |
| **Blood / Circulation** | ☐ Easy Bleeding ☐ Easy Bruising |
| **Allergic / Immunologic** | ☐ Seasonal Allergies |
| **Other** | ☐ |
| **OR:** | ☐ ***NOT EXPERIENCEING ANY SYMPTOMS AT THIS TIME*** |

| | **PAST MEDICAL HISTORY** |
|---|---|
| **PLEASE CHECK ANY PREVIOUSLY DIAGNOSED CONDITIONS:** | ☐ Alzheimer's Disease ☐ Anemia ☐ Aneurysms ☐ Anxiety Disorder ☐ Arthritis ☐ Asthma ☐ Atrial Fibrillation<br>☐ Bell's Palsy Bipolar Disorder Cancer/ Hx of Cancer Cerebral Palsy Chronic Heart Failure<br>☐ COPD ☐ Dementia ☐ Depression ☐ Eczema ☐ Emphysema ☐ Epilepsy ☐ Fibromyalgia<br>☐ Giant Cell Arteritis ☐ Heart Disease ☐ Hepatitis A/B/C ☐ Herpes Zoster ☐ High Cholesterol<br>☐ HIV/AIDS ☐ Hypertension ☐ Hypothyroid ☐ Hyperthyroid ☐ Kidney Disease ☐ Migraines<br>☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Osteoporosis ☐ Pacemaker/Defibrillator ☐ Parkinson's Disease<br>☐ Pneumonia ☐ Polymyalgia Pneumatica ☐ Prediabetes ☐ Rheumatoid Arthritis ☐ Seizure Disorder<br>☐ Sinusitis ☐ Sjoren's Syndrome ☐ Stroke/ TIA-Previous ☐ Tuberculosis ☐ Ulcers ☐ Vertigo<br>☐ Other:<br>**DIABETES (please check one below):**<br>**TYPE II-**<br>**☐ INSULIN DEPENDENT**<br>**☐ NON-INSULIN DEPENDENT**<br>**TYPE I-**<br>**☐ INSULIN DEPENDENT**<br>**☐ NON INSULIN DEPENDENT**<br>**OR PLEASE SELECT: (☐ No previously diagnosed conditions** |

| Diabetic Information | | |
|---|---|---|
| **Type of Test** | | |
| **SMBS: Self Monitoring Blood Sugar test** | **Date of Last Recorded Test** | |
| | **Value** | |
| | **Location / Timing** | |
| **HgbA1c: Hemoglobin A1c test** | **Date of Last Recorded Test** | |
| | **Value** | |
| | **Location / Timing** | |

| Surgical Information- Please list all past surgeries | | | | |
|---|---|---|---|---|
| **Date** | **Eye** | **Procedure** | **Surgeon** | **Complications** |
| | | | | |

| Surgical Information- Please list all past surgeries | | | | |
|---|---|---|---|---|
| **Date** | **Eye** | **Procedure** | **Surgeon** | **Complications** |
| | | | | |
| | | | | |
| | | | | |

| Medications | | | |
|---|---|---|---|
| **Please cross out any medications that you are no longer taking**<br>**Please list all prescriptions, over the counter and herbal medications**<br><br>****If you are not on any medications at this time, please indicate NONE below** | | | |
| **Date** | **Name** | **Strength** | **Directions** |
| | | | |
| | | | |
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| | | | |

| Past / Present Ocular History | | |
|---|---|---|
| **Please CIRCLE all that apply and FILL IN any missing information** | | **Date/ Duration** |
| **Last Eye Exam:** | Date: | |
| **Cataracts** | ☐ YES ☐ NO If Yes, have you ever had any surgery? ☐ YES ☐ NO When? | |
| **Glaucoma** | ☐ YES ☐ NO If yes, have you ever had any surgery? ☐ YES ☐ NO When? | |
| **Vision** | Vision Loss/ Changes: How long? Blurry/ Double Vision: How long? | |
| **Retinal Disease** | ☐ YES ☐ NO If yes, have you ever had any surgery? ☐ YES ☐ NO When? | |
| **Glasses/ Contacts** | ☐ YES ☐ NO If yes, how long have you been wearing? | |
| **Pain** | ☐ YES ☐ NO If yes, how long? | |
| **Redness** | ☐ YES ☐ NO If yes, how long? | |
| **Flashing Lights** | ☐ YES ☐ NO If yes, how long? | |
| **Floaters/ Specks** | ☐ YES ☐ NO If yes, how long? | |
| **Dry Eyes** | ☐ YES ☐ NO If yes, how long? | |
| **Other:** | | |

| | | | |
|---|---|---|---|
| **Do you work on a computer?** | | **Hours per day** | |

| Social History | |
|---|---|
| **What type of recreational drugs do you use?** | |
| **What type of alcohol do you drink, how** | |

| Social History | |
|---|---|
| **much and how often?** | |
| **Are you a smoker, former smoker or never smoked? Do you smoke everyday or some days?** | |

| Family History | |
|---|---|
| **Please list any family members with these conditions**<br><br>MGM (maternal grandmother) PGM (paternal grandmother) MGP (maternal grandparents)<br>MGF (maternal grandfather) PGF (paternal grandfather) PGP (paternal grandparents) | |
| **Glaucoma** | |
| **Cataracts** | |
| **Macular Degeneration** | |
| **Eye Injury** | |
| **Retinal Disease** | |
| **Other Disease** | |
| **Blindness** | |
| **Strabismus** | |
| **Amblyopia** | |
| **Diabetes** | |
| **Cancer** | |
| **Heart Disease** | |
| **Hypertension** | |
| **High Cholesterol** | |
| **Kidney Disease** | |
| **Other** | |
| **Or please check:** | ☐ I am adopted and my family history is unknown. |

| Allergies- IF YOU HAVE NO ALLERGIES, PLEASE WRITE NONE | | | |
|---|---|---|---|
| **Allergy** | **Onset Date** | **Reaction** | **Severity** |
| | | | |
| | | | |
| | | | |

| Contact Lens History | | | | | |
|---|---|---|---|---|---|
| **Type of contact lenses you currently use** (gas permeable, soft daily, extended) | | | **How often do you replace your contacts?** (daily, weekly, monthly) | | |
| **Average number of hours that you wear your contacts** | | **Number of hours worn today** | | **Wearing Type** (daily, extended) | |