Fier Eye Care & Surgery Center
1441 East Ocean Blvd.
Stuart, FL 34996
Phone: (772) 286-0007
Fax: (772) 283-5467

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

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)286-0007 so that we may assist you.

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

We look forward to seeing you.

Directions To the Stuart Office

From the SOUTH (traveling NORTH on US1): Make a RIGHT on SE Monterey Road. Make a LEFT onto East Ocean Boulevard. The next intersection is Martin Avenue. Our office sits on the NORTH (right) corner of this intersection, no suite number. You must turn RIGHT onto Martin Ave. to pull into the parking lot.

From the NORTH (traveling SOUTH on US1): Make a LEFT on SE Monterey Road. Make a LEFT onto East Ocean Boulevard. The next intersection is Martin Avenue. Our office sits on the NORTH (right) corner of this intersection, no suite number. You must turn RIGHT onto Martin Ave. to pull into the parking lot.

FROM I-95: Take the Stuart/ Indiantown Exit (#101). Take SR76/ Kanner Highway EAST. When you get to Monterey Road, make a RIGHT. Follow this road through US1, over the railroad tracks, and past the airport. Make a LEFT onto East Ocean Boulevard. The next intersection is Martin Avenue. Our office sits on the NORTH (right) corner of this intersection, no suite number. You must turn RIGHT onto Martin Ave. to pull into the parking lot.

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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 ☐ Cell Phone ☐ Work Phone **OR** ☐ No Voicemail	**Please Check:**	☐ I understand that email is not a secured medium for transmitting personal health information.		

Information			
Primary Language (Please check)	English ☐ Spanish ☐ French ☐ Italian ☐ Other: ☐	**Marital Status (Please check)**	Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other: ☐
Race (Please check)	American Indian ☐ Asian ☐ African American ☐ Native Hawaiian other Pacific Islander ☐ White ☐ Other Race ☐	**Ethnicity (Please check)**	Non-Hispanic or Latino ☐ 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**	
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 ☐ No

Other Contacts							
Sal	**First**	**M**	**Last**	**Relation**	**Home#**	**Cell#**	**Permission to release personal health information:**
							☐ Yes ☐ 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 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 ☐ Bell's Palsy ☐ Bipolar ☐ Disorder ☐ Cancer/ Hx of Cancer ☐ Cerebral Palsy ☐ Chronic Heart Failure ☐ COPD ☐ Dementia ☐ Depression ☐ Eczema ☐ Emphysema ☐ Epilepsy ☐ Fibromyalgia ☐ Giant Cell Arteritis ☐ Heart Disease ☐ Hepatitis A/B/C ☐ Herpes Zoster ☐ High Cholesterol ☐ HIV/ AIDS ☐ Hypertension ☐ Hyperthyroid ☐ Hypothyroid ☐ Kidney Disease ☐ Migraines ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Osteoporosis ☐ Pacemaker/ Defibrillator ☐ Parkinson's Disease ☐ Pneumonia ☐ Polymyalgia Pneumatica ☐ Prediabetes ☐ Rheumatoid Arthritis ☐ Seizure Disorder ☐ Sinusitis ☐ Sjoren's Syndrome ☐ Stroke/ TIA-Previous ☐ Tuberculosis ☐ Ulcers ☐ Vertigo ☐ OTHER: **DIABETES (please check one below):** **TYPE II-** **☐ INSULIN DEPENDENT** **☐ NON-INSULIN DEPENDENT** **TYPE I-** **☐ INSULIN DEPENDENT** **☐ NON INSULIN DEPENDENT** ***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**

Medications			
Please cross out any medications that you are no longer taking **Please list all prescriptions, over the counter and herbal medications** ****If you are not currently taking any medications, please indicate NONE below:**			
Date	**Name**	**Strength**	**Directions**

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?	

Social History	
What type of alcohol do you drink, how 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 MGM (maternal grandmother) PGM (paternal grandmother) MGP (maternal grandparents) 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	
Or please check:	☐ I am adopted and my family history is unknown
Other	

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)	