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415 N. Causeway, New Smyrna Beach, FL 32169
(386) 427-414

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(386) 402-7328

Patient Name_____ DOB_____

Name of parents/guardian if under 18_____

Social Security #_____

Mailing Address_____

City_____ State_____Zip_____

Phone Numbers_____
Home Cell Work

Email Address (used for appointment confirmations)_____

Employer Name/Address/Phone (mandatory for Workman's Comp)

_____

_____

Marital Status (circle one) Single Married Divorced Widowed

Race (circle all that apply) White Black Asian Indian

Other_____

Preferred Language (circle one) English Spanish Other_____

Primary Care Physician_____

Pharmacy Name_____ Location_____

Past Medical History

Check all that apply:

____ NONE

____ Anxiety Disorder

____ Arthritis

____ Asthma

____ AFIB (Atrial Fibrillation)

____ Stroke (Cerebrovascular Accident)

____ COPD (Chronic Obstructive Lung Disease)

____ Coronary Arteriosclerosis

____ Depressive Disorder

____ Diabetes Mellitus (Type 1 / Type 2)

____ End-Stage Renal Sisease

____ Epilepsy

____ GERD (Gastroesophagael reflux disease)

____ High Blood Pressure (Hypertension)

____ Hearing Loss

____ HIV (Human Immunodeficiency Virus)

____ High Cholesterol (Hypercholeserolemia)

____ Hyperthyroidism

____ Hypothyroidism

____ Hepatitis (Inflammatory Disease of the liver
Type:_____

____ Leukemia

____ Lymphoma (Malignant Lymphoma)

____ Lung Cancer (Malignant Tumor of Lung)

____ Breast Cancer (Malignant Tumor of Breast)

____ Colon Cancer (Malignant Tumor of Colon)

____ Prostate Cancer (Malignant Tumor of Prostate)

Other (please list)

_____

_____

Surgical History

Check all that apply:

____ NONE

____ Biopsy of Breast

____ Coronary Artery Bypass Graft

____ Kidney Transplant (Entire Transplanted Kidney)

____ Excision of Basal Cell Carcinoma

____ Excision of Melanoma

____ Excision of Squamous Cell Carcinoma

____ History of Colostomy

____ History of Tubal Ligation

____ History of Appendix Removal (Appendectomy)

____ History of Gallbladder (Cholecystectomy)

____ History of Colon Removal (Colectomy)

____ History of Liver Excision

____ History of Tissue Graft Heart Valve Replacement

____ History of Bladder Removal (Total Cystectomy)

____ Uterus (Hysterectomy)

____ Kidney Biopsy

____ Lumpectomy of Breast (Left / Right)

____ Mastectomy of Breast (Left / Right)

____ Mechanical Heart Valve Replacement

____ Ovary Removal (Oophorectomy)

____ Pancreas (Pancreatectomy)

____ Kidney Stone Removal (Percutaneous Extract)

____ Prostate (Prostatectomy)

____ Spleen (Splenectomy)

____ Biopsy of skin (Surgical Biopsy)

____ Kidney Removal (Total Nephrectomy)

____ Testical Removal (Total Orchidectomy)

____ Total Replacement of Hip Joint (Left / Right)

____ Total Replacement of Knee Joint (Left / Right)

____ Transplantation of Heart

____ Transplantation of Liver

Other (please list)

_____

_____

_____

Ocular History

Check all that apply:

____ Allergic Conjunctivitis
____ Blepharitis
____ Cataract (Left / Right)
____ Contact Lenses
____ Corneal Dystrophy (Left / Right)
____ Diabetic Retinopathy, Background (Left / Right)
____ Diabetic Retinopathy, Proliferative (Left / Right)
____ Dry Eyes
____ Glasses
____ Glaucoma (Left / Right)
____ Macular Degeneration (Left/Right)
____ Macular ERM (Left / Right)
____ Narrow Angles (Left / Right)
____ Ocular Hypertension (Left / Right)
____ Ophthalmic Migraine
____ Pseudoexfoliation
____ Retinal Detachment (Left/Right)
____ Retinal Tear (Left / Right)
____ Strabismus
____ Vitreous Floaters (Left / Right)
____ NONE

____ Other (please list) _____

Ocular Surgery

Check all that apply:

____ Blepharoplasty (Left / Right)
____ Cataract Surgery (Left / Right)
____ Corneal Transplant (Left / Right)
____ DSAEK (Left / Right)
____ Eye Muscle Surgery
____ Intravitreal Injections (Left / Right)
____ LASIK (Left / Right)
____ LPI (Left / Right)
____ PRK (Left / Right)
____ Ptosis Repair (Left / Right)
____ Punctal Plugs (Left / Right)
____ SLT (Left / Right)
____ Strabismus Surgery
____ Retinal Laser (Left / Right)
____ Trabeculectomy (Left /Right)
____ YAG Capsulotomy (Left/Right)
____ NONE

____ Other (please list)_____

_____

Medications and Allergies

*Please list all prescription and Over-the-Counter medications you currently take including ALL eye drops OR provide a copy of your medication list.

Medication Name	Dose	Frequency Am / PM or BOTH

Allergies (please list):_____

_____

Social History

*Circle all that apply:

Cigarette Smoking: Never Former Smoker Daily Less Than Daily

Alcohol Use: Never Less Than Daily 1-2 Daily 3 or More Daily

Illicit Drug Use? Yes No IV Drug Use? Yes No

Do You Drive? Daytime Only Day & Night I Do Not Drive

Do you feel safe while at home? Yes No

Family History

Glaucoma Mother? ____YES ____NO Father? ____YES ____NO

Macular Degeneration Mother? ____YES ____NO Father? ____YES ____NO

Please circle any of the following if it pertains to you:

Poor Vision

Eye pain

Tearing

Redness

Jaw Pain

Amaurosis Fugax

Loss of Vision

Fever

Chills

High Blood Pressure

Rapid Heart Beat

Shortness of Breath

Arthritis

Rash

Headache

Seizures

Stroke

Paralysis

Anxiety

Depression

Insomnia

Diabetes

Thyroid Abnormalities

Bleeding

Anemia

Allergies

Hay Fever

Hives

Allergy to Adhesive

Allergy to Lidocaine

Blood Thinners

Defibrillator

Flomax

MRSA

Narrow Angles

Pacemaker

Premedication prior to procedures

Rapid heartbeat with epinephrine

Pregnancy or planning a pregnancy

Pseudoexfoliation syndrome

Artificial heart valve

Steroid responder

Artificial joints within past 2 years

Privacy Practice Acknowledgment Form

I have received the *Notice of Privacy Practices* and I have been provided an opportunity to review it.

Name: _____

Signature: _____

Date of Birth: _____ Today's Date: _____

Insurance Signature Authorization:

I authorize any holder of medical or other information about me to release to Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers, or to the billing agent of this physician or supplier any info needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts the assignment.

I understand that this is a lifetime signature authorization.

_____ _____

Signature of patient (or guardian) Date

Responsible party/authorized signer IF other than patient:

Relation to patient: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SS#: _____

Emergency Contact:

Name: _____

Phone: _____ Relationship to patient: _____

I authorize Volusia Eye Associates to release personal health information to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Patient's Signature Date

_____ I authorize Volusia Eye Associates to import my medication list from Surescripts.