OPTICAL OUTFITTERS
FITTING VISION TO YOUR LIFESTYLE

242 HARBOR VILLAGE LANE
APOLLO BEACH FL 33572
PHONE: 813.645.2022
WWW.OPTICAL-OUTFITTERS.COM

PATIENT HISTORY

Today's Date: _____/_____/_____

Name: _____ □ **M** □ **F** **Date of Birth:** _____/_____/_____

Address (if different than license):_____

City:_____ **State:** _____ **Zip:** _____

Home Phone (_____)_____ **Cell**(_____)_____

Work (_____)_____ **Preferred contact** □ Home □ Cell □ Work

Email: _____ **Can we send you reminders and updates?** □ Yes □ No

Insurance: _____ **Member ID** _____

How did you hear about this office?

□ Referral □ Internet search □ Walk-by □ Previous patient □ Insurance

□ Advertisement _____ □ Friend/Family _____ □ Local Event _____

EYE HISTORY

Reason for today's visit? □ Glasses □ Contacts □ Other

Date of last eye exam? _____ **Physician/Facility** _____

Please list any eye surgery and date: _____
Please list any eye injuries and date: _____
Do you or anyone in your family have any of the following eye conditions?

	Self	Relative	None
Cataracts	□	□	□
Glaucoma	□	□	□
Macula Degeneration	□	□	□
Retinal tear or detachment	□	□	□
Lazy eye/ amblyopia	□	□	□

Are you currently experiencing any of the following eye symptoms?

□ Blurry vision
□ Redness
□ Dryness
□ Itching
□ Pain
□ Double vision
□ Light sensitivity/ Glare
□ Floaters
□ Flashes
□ Other
_____

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MEDICAL HISTORY

Primary Care Physician:_____ **Last PCP Visit:** _____

Do you or anyone in your family have any of the following medical conditions?

	Self	Relative	None
Diabetes	□	□	□
High blood pressure	□	□	□
High Cholesterol	□	□	□
Heart Disease	□	□	□
Thyroid Disease	□	□	□
Asthma	□	□	□
Stroke	□	□	□
Arthritis	□	□	□
Autoimmune _____	□	□	□
Other _____	□	□	

Please list any allergies: _____

Please list any current medications, including over-the-counter and vitamins:

_____
_____
_____
_____
_____
_____
_____
_____
_____

REVIEW OF SYSTEMS

Are you CURRENTLY experiencing any of the following symptoms? (Check all that apply)

□ Sudden weight gain or loss
□ Chronic fatigue or fever
□ **Heart**: chest pain, irregular heart beat
□ **Respiratory**: cough, wheezing, shortness of breath, asthma
□ **Ear/Nose/Throat**: sore throat, sinus problems, earache, hearing loss
□ **Pregnant or Nursing**

□ **Gastrointestinal**: abdominal pain, bowel problems, vomiting
□ **Urinary**: pain upon urination, blood in urine
□ **Hematologic/Lymphatic**: blood disorders, enlarged glands
□ **Endocrine**: thyroid
□ **Integumentary**: rashes, dry skin

□ **Musculoskeletal**: joint pain, stiffness, swelling, muscle pain
□ **Neurological**: numbness, headache, seizures, paralysis
□ **Allergic/Immunologic**: reaction to food, drugs, allergies
□ **Psychiatric**: depression, anxiety, insomnia, confusion

If yes, please explain

_____

SOCIAL HISTORY:

Marital status: □ Single □ Married □ Divorced □ Widowed

Do you use: □ Alcohol □ Tobacco □ Other substances If yes, how often? _____

Occupation: _____ Hobbies: _____

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DILATION

The Florida Board of Optometry REQUIRES a dilated fundus exam during a comprehensive eye exam unless otherwise requested by the patient. Dilation will cause your pupils to enlarge and allows for a more thorough examination of the retina. The dilation drops take 15-20 minutes to take effect and will last between 2-6 hours. You will become more sensitive to light and may experience blurry vision at near. Distance vision is generally not affected and driving should not be an issue.

☐ **I understand the importance and effects of dilation.**

CONTACT LENS EVALUATION

Contact lenses are considered a medical device; therefore an accurate fitting must be performed to make sure the lenses fit your eyes properly. The exam will evaluate the curvature and health of your eyes to determine if you are a good candidate for contact lenses. The fitting includes trial lenses to determine the best prescription and brand for your eyes. Follow-up care is included up to 2 months after the initial exam.
Any follow-up visits after 2 months will be charged a re-fit fee.

☐ **I understand the contact lens fitting procedure and fees.**

AUTHORIZED USERS

We are committed to maintaining the privacy of your protected health information. We will only disclose information about your account and health information with your consent. This includes picking up prescriptions and orders, discussions about fees and any information pertaining to your health records. Please list any individuals that you consent to have access to your account information.

☐ **I authorized the following individuals to be released information about my account and health information.**

Name _____ Relationship_____

Name _____ Relationship_____

Name _____ Relationship_____

Patient Signature _____ Date: _____/_____/_____