

**EYE-SITE OF BOYNTON BEACH**

6641 W BOYNTON BEACH BLVD

BOYNTON BEACH, FL 33437

PH: 561-738-0111

FX: 561-735-9359

**PATIENT INFORMATION**

|                                    |  |                  |  |
|------------------------------------|--|------------------|--|
| <b>NAME:</b>                       |  | <b>DOB:</b>      |  |
| <b>PHONE:</b>                      |  | <b>EMAIL:</b>    |  |
| <b>ADDRESS:</b>                    |  |                  |  |
| <b>EMERGENCY CONTACT:</b>          |  | <b>PHONE:</b>    |  |
| <b>OCCUPATION:</b>                 |  | <b>EMPLOYER:</b> |  |
| <b>HOW DID YOU HEAR ABOUT US?:</b> |  |                  |  |

**OCULAR HISTORY**

|   |  |   |  |
|---|--|---|--|
| <b>LAST EYE EXAM (APPROXIMATE DATE):</b>  |  |   |  |
| <b>PLEASE SELECT ALL VISION CORRECTION/EYEWEAR YOU CURRENTLY USE:</b>   |  |   |  |
| <b>GLASSES:</b><br><input type="checkbox"/> DISTANCE ONLY GLASSES<br><input type="checkbox"/> PROGRESSIVE GLASSES<br><input type="checkbox"/> BIFOCAL/TRIFOCAL GLASSES<br><input type="checkbox"/> READING GLASSES (OTC)<br><input type="checkbox"/> READING GLASSES (PRESCRIPTION)<br><input type="checkbox"/> COMPUTER GLASSES<br><input type="checkbox"/> BLUE LIGHT BLOCKING GLASSES<br><input type="checkbox"/> SUNGLASSES |  | <b>CONTACT LENSES:</b><br><input type="checkbox"/> DISTANCE ONLY CONTACT LENSES<br><input type="checkbox"/> MULTIFOCAL CONTACT LENSES<br><input type="checkbox"/> MONOVISION CONTACT LENSES<br><input type="checkbox"/> MYOPIA CONTROL CONTACT LENSES<br><input type="checkbox"/> CORNEAL RGP CONTACT LENSES<br><input type="checkbox"/> SCLERAL RGP CONTACT LENSES |  |
| <b>HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING EYE CONDITIONS:</b>   |  |   |  |
| <input type="checkbox"/> AGE-RELATED MACULAR DEGENERATION<br><input type="checkbox"/> GLAUCOMA<br><input type="checkbox"/> CATARACTS<br><input type="checkbox"/> DRY EYE<br><input type="checkbox"/> DIABETIC RETINOPATHY   |  | <input type="checkbox"/> RETINAL HOLE/TEAR/DETACHMENT<br><input type="checkbox"/> KERATOCONUS<br><input type="checkbox"/> AMBLYOPIA (LAZY EYE/EYE TURN)<br><input type="checkbox"/> MEIBOMIAN GLAND DYSFUNCTION   |  |
| <b>HAVE YOU HAD ANY OF THE FOLLOWING EYE SURGERIES:</b>   |  |   |  |
| <input type="checkbox"/> LASIK/PRK<br><input type="checkbox"/> CATARACT SURGERY<br><input type="checkbox"/> RETINAL DETACHMENT REPAIR   |  | <input type="checkbox"/> STRABISMUS/LAZY EYE CORRECTION<br><input type="checkbox"/> GLAUCOMA MANAGEMENT SURGERY/LASER<br><input type="checkbox"/> OTHER:  |  |
| <b>PLEASE LIST ANY EYE VITAMINS OR EYE DROPS YOU USE:</b>   |  |   |  |
| <input type="checkbox"/> PRESERVISION/AREDS2<br><input type="checkbox"/> GLAUCOMA EYE DROPS (NAME/CAP COLOR & FREQUENCY, IF KNOWN):<br>_____<br><input type="checkbox"/> ANTI-REDNESS DROPS (BRAND, IF KNOWN):<br>_____   |  | <input type="checkbox"/> ARTIFICIAL TEARS (BRAND, IF KNOWN):<br>_____<br><input type="checkbox"/> ALLERGY EYE DROPS (BRAND, IF KNOWN):<br>_____<br><input type="checkbox"/> OTHER:<br>_____   |  |

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**MEDICAL HISTORY****HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS:**

- |  |  |
|--|--|
| <input type="checkbox"/> DIABETES ( <input type="checkbox"/> TYPE 1 <input type="checkbox"/> TYPE 2) | <input type="checkbox"/> THYROID DYSFUNCTION |
| <input type="checkbox"/> HIGH BLOOD PRESSURE   | <input type="checkbox"/> HISTORY OF STROKE   |
| <input type="checkbox"/> HIGH CHOLESTEROL  | <input type="checkbox"/> OTHER:              |
| <input type="checkbox"/> HEART DISEASE   |  |

**PLEASE LIST ANY DRUG ALLERGIES:** ☐ N/A ☐ OTHER:**PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:**

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