glasses 2day @Citrus Vision

Patient Forms

Dr Brad Cook OD
2332 Hwy 44 W
Inverness, Fl 34453
352-726-2085
citrusvisionclinic.com

Today's Date_____

Name_____

Address & Zip code_____

_____

Main Phone_____ Cell- Yes No

Date of Birth_____ SSN _____

Gender at birth?_____

Employer _____

Occupation _____ Spouse Name_____

Email Address_____

What concerns would you like addressed at your appointment?

_____

_____

Do you currently wear glasses? Yes No Cheaters only

Do you currently wear contacts? Yes No Occasionally

Do you work on a computer 4+ hours daily? Yes No Sometimes

How many pair of glasses do you currently have? _____

_____

Do you wear sunglasses when outdoors? Yes No Transitions

Do you have computer glasses? Yes No

Are your glasses: Progressive Bifocal/Trifocals Distance only

Have you been diagnosed with any of the following:

Glaucoma Cataracts Macular Degeneration

Corneal Dystrophy Graves Disease Diabetes A1C_____

Diabetic Retinopothy Retinal Detatchment Iritis/Uveitis

Dry Eyes Floaters High Eye Pressure

Eye Muscle Surgery Lazy Eye

Hashimotos Brain Tumor Lupus or MS

Have you had Chemo or Radiation in last Six Months? Yes No

Have you had cataract surgery? Yes No **Lasik?** Yes No

PRK? Yes No **RK?** Yes No

Medical Insurance Company_____

Member/Subscriber Number _____

Subscribers Name_____

Subscribers Date of Birth _____

Relationship to subscriber _____

Vision Insurance _____

Member number_____

Subscriber name _____

Subscriber Date of Birth_____ SSN_____

_____

Medications (medications can cause vision changes, it is important we know ALL of your medications)

_____ _____

_____ _____

_____ _____

Medication allergies_____

Medical History: Primary Care Dr_____

Seasonal Allergies Environmental Allergies Hay Fever

Asthma Heart Disease High Blood Pressure

Kidney Disease High Cholesterol Sarcoidosis

Arthritis Rheumatoid Arthritis Neurological condition

Thyroid disease: Fast Slow Hashimotos

_____

Date of last Eye Exam _____

Location of Last Eye Exam

_____

Please List the names of people that we are allowed to share health information with & has permission to pick up your order.

_____

_____

_____

Signature Date

_____ _____

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Welcome to our Optical! We provide SAME DAY GLASSES and the exams done by our optometrist are Healthy Eye Care Exams only. Healthy Eye Care is for people that Do NOT have eye disease or symptoms of eye disease, or have a medical condition that can negatively affect the eyes or vision. We do see people that have had cataract surgery with no vision changes or any other eye disease issues. We do exams for children 12 and older, a child should have their first eye exams done by a pediatric ophthalmologist; we do have recommendations. Vision Plans only cover Healthy Eye Exams, they do not pay to treat or diagnose eye diseases.

Healthy Eye Exams do not cover problems, injuries, or infections with eyes. If you experience floaters or black spots in your vision, that is not a healthy eye exam. Anyone with advanced cataracts, hashimotos, graves disease, lupus, MS, uncontrolled diabetes, glaucoma, macular degeneration, diabetic retinopothy, undergoing or have had chemo within the last 6 month, or taking medications that can cause visual changes should see an Ophthalmologist for all eye exams. We are not an ophthalmologist office. Ophthalmologist are the eye doctors that handle medical eye care and perform cataract surgery.

Outside prescriptions for glasses are absolutely welcome if you wish to utilize our excellent Optical expertise. We have a large amount of fashionable frames and use high quality lenses at competitive prices.

Contact lens exams are a service that we do in our optical, however we do not fit multifocal or rigid gas permeable contact lenses. We are not currently doing exams for those that would be new to contacts.

Office Payment Policy

Payment for exam and glasses is expected at time of service. The glasses payment can be half down for the order to be placed and the other half when the glasses are picked up. Contact lenses need to be paid in full before the order is placed. There is a handling fee on all contact lens orders that are under a year supply.

All year supply of contact lens order are directly shipped to your home at no extra charge to you.

Glasses are made to order, this means that they are a specialty item. There are no refunds for glasses at Glasses 2 Day @ Citrus Vision.

I understand that Glasses 2Day @ Citrus Vision does not see medical eye exams. I understand the payment policy on glasses and contact lens orders. I agree to the terms.

Signature _____ Date _____

Glasses 2Day @ Citrus Vision
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352-726-2085
info@citruseye.com

Today's Date _____

Medical History

Patient Information

Name (Last)	(First)	Date of Birth

Medical History (Of particular interest are immediate family members such as parents, siblings, or children)

Have you ever had any of the following?	Self	Have you or a member of your family had any of the following?	Self	Relative/ Relationship
Allergies	☐	Adopted	☐	Please skip if history is unknown
Anorexia or Bulimia	☐	Arthritis	☐	☐ _____
Behcet's Disease	☐	Bell's Palsy	☐	☐ _____
Blepharitis	☐	Blindness	☐	☐ _____
Born premature	☐	Cataract	☐	☐ _____
Chlamydia or Trachoma	☐	Cancer	☐	☐ _____
Corneal ulcers	☐	Color blindness	☐	☐ _____
Conjunctivitis	☐	Eye surgery	☐	☐ _____
Dry Eye	☐	Fuch's Dystrophy	☐	☐ _____
Fibromyalgia	☐	Diabetes	☐	☐ _____
German Measles	☐	Genetic disorders	☐	☐ _____
Gonorrhea	☐	Glaucoma	☐	☐ _____
Hepatitis	☐	Grave's Disease	☐	☐ _____
Herpes	☐	Heart disease	☐	☐ _____
Histoplasmosis	☐	High Blood Pressure	☐	☐ _____
Iritis/Uveitis	☐	High Eye Pressure	☐	☐ _____
Keratoconus	☐	LASIK surgery	☐	☐ _____
Lazy eye	☐	Lupus	☐	☐ _____
Lyme Disease	☐	Macular Degeneration	☐	☐ _____
Pneumonia	☐	Migraine Headaches	☐	☐ _____
Psoriasis	☐	Multiple Sclerosis	☐	☐ _____
Shingles or Zoster	☐	Myasthenia gravis	☐	☐ _____
Syphilis	☐	Optic Neuritis	☐	☐ _____
Temporal Arteritis	☐	Reiter's Syndrome	☐	☐ _____
Toxocariasis	☐	Retinitis Pigmentosa	☐	☐ _____
Toxoplasmosis	☐	Retinal Detachment	☐	☐ _____
Trichasis	☐	Rosacea	☐	☐ _____
Tuberculosis or TB	☐	Sarcoid	☐	☐ _____
Other _____	☐	Sjögren's Syndrome	☐	☐ _____
Other _____	☐	Stevens-Johnson Syndrome	☐	☐ _____
Other _____	☐	Stroke	☐	☐ _____
Other _____	☐	Thyroid Disease	☐	☐ _____

Review of Systems- Do you currently or have you ever had any problems in the following areas?

System	Yes	No
Constitutional		
Fever	☐	☐
Weight loss/gain	☐	☐
Hot/cold intolerance	☐	☐
Fatigue/tire easily	☐	☐
Integumentery (Skin)		
Easy bruising	☐	☐
Rashes/facial acne	☐	☐
Pigmented or white spots on skin	☐	☐
Lumps in the skin	☐	☐
Tick bites	☐	☐
Neurological		
Numbness or tingling of extremities	☐	☐
Seizures	☐	☐
Eyes		
Loss of vision	☐	☐
Blurred vision	☐	☐
Distorted vision/halos	☐	☐
Loss of side vision	☐	☐
Double vision	☐	☐
Flashes/floaters in vision	☐	☐
Mucus discharge	☐	☐
Sties or chalazion	☐	☐
Chronic infection of eye or lid	☐	☐
Dryness	☐	☐
Redness	☐	☐
Itching	☐	☐
Burning	☐	☐
Sandy or gritty feeling	☐	☐
Foreign body sensation	☐	☐
Excess tearing/watering	☐	☐
Glare/light sensitivity	☐	☐
Eye pain or soreness	☐	☐
Tired eyes	☐	☐
Psychiatric		
Depression	☐	☐
Allergic/ Immunologic		
Allergies/hay fever	☐	☐
Exposed to AIDS (HIV)	☐	☐

	Yes	No
Ears, Nose, Mouth, Throat		
Recent viral infection	☐	☐
Sinus congestion	☐	☐
Sores in mouth	☐	☐
Loss of hearing or deafness	☐	☐
Runny nose	☐	☐
Post-nasal drip	☐	☐
Chronic cough	☐	☐
Dry throat/ mouth	☐	☐
Endocrine		
Thyroid/other glands	☐	☐
Genitourinary (genitals/ kidneys/ bladder)		
Burning with urination	☐	☐
Used IV drugs	☐	☐
Genital sores	☐	☐
Kidney infection or bleeding	☐	☐
Respiratory		
Asthma	☐	☐
Smoking	☐	☐
Chronic bronchitis	☐	☐
Emphysema	☐	☐
Vascular/ Cardiovascular		
Heart pain	☐	☐
Vascular disease	☐	☐
Gastrointestinal		
Diarrhea	☐	☐
Constipation	☐	☐
Stomach pain	☐	☐
Bones/ Joints/ Muscles		
Muscle or neck pain	☐	☐
Back pain or stiffness	☐	☐
Joint pains or stiffness	☐	☐
Pain with chewing	☐	☐
Rheumatoid arthritis	☐	☐
Lymphatic/ Hematologic		
Alcoholism	☐	☐
Cirrhosis/ liver disease	☐	☐
Anemia	☐	☐
Bleeding problems	☐	☐
Blood transfusion	☐	☐

Please list all medications to which you are allergic.

_____

_____

_____

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RECORDS RELEASE

Please Release Records for Patient:

_____

Date of Birth_____

Release From:

Previous Dr Name _____

Dr Address_____

Dr Phone Number_____

Dr Fax Number_____

Please include:

*Most Recent Eye Exam
*Any Medical Eye Test
*Prescription for Glasses & Contacts

Fax to: Glasses 2 Day @ Citrus Vision Fax:352-726-2738 Phone: 352-726-2085

Signed_____ Date_____