GULFCOAST EYE CARE

Name: Mr. Mrs. Miss Ms. Dr. _____
Last First Middle

Age: _____ Date of Birth: _____ Marital Status: _____ Social Security No.: _____

Do you live: ❑Alone ❑With Spouse ❑At Care Center ❑Other _____ Spouse's Name: _____

Local Address: _____
Street/PO Box City State Zip Code

Local Phone: Home: _____ Cell: _____ Work: _____

Other Address: _____
Street/PO Box City State Zip Code

Email Address: _____ Other Phone: _____

Emergency Contact: _____
Name Relationship Phone Number

Occupation (if retired, list occupation prior to retirement): _____

How did you hear about us? (check any boxes that apply)

❑Physician Referral	❑Patient Referral	❑Employee Referral	❑Other_____
❑Website	❑Seminar	❑Health Insurance	❑Event _____
❑Yellow Pages	❑Direct Mail	❑Locateadoc.com	❑Television, please specify:_____
❑AYP	❑Exterior Sign	❑Facebook	❑Newspaper, please specify: _____

Please check the appropriate box to indicate whether you now have, or have ever had, any of the following:

YES	NO		YES	NO		YES	NO	
❑	❑	Diabetes	❑	❑	Thyroid Problem	❑	❑	Kidney Stones
❑	❑	High Blood Pressure	❑	❑	Arthritis	❑	❑	Kidney Failure
❑	❑	Heart Attack or Failure	❑	❑	Asthma	❑	❑	Bleeding Abnormalities
❑	❑	Irregular Heart Beat	❑	❑	Emphysema	❑	❑	Lupus
❑	❑	Stroke	❑	❑	Bronchitis	❑	❑	Cold Sore/Fever Blister
❑	❑	Cancer_____	❑	❑	Ulcer	❑	❑	Other_____

Please list any medications, including vitamins, which you are taking: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you currently or have you ever taken tamsulosin (Flomax)? ❑YES ❑NO

Please list any allergies to medication(s): _____

Do any of your close relatives have: ❑Glaucoma ❑Retinal Detachment ❑Macular Degeneration ❑Other_____
❑No family history of eye diseases

	YES / NO		YES / NO	
Do you smoke?	❑ ❑	Are you pregnant or nursing?	❑ ❑	Do you wear contacts? ❑ ❑
Do you drive	❑ ❑	Have you had LASIK or RK?	❑ ❑	❑Hard Contacts/RGP ❑Soft Contacts ❑Toric

Please list any eye surgery or laser treatment you have had: _____

Primary Physician: _____

Date of Last Eye Exam: _____

How old are your current glasses? _____

Where were they purchased?_____

Preferred Pharmacy/Location:_____

For Office Use Only
Updated _____ by _____
Updated _____ by _____
Updated _____ by _____
Updated _____ by _____