Manatee Family Eye Care
501 Village Green Parkway, S. 3 Bradenton, FL 34209 (941)-792-7522
319 7th St W. Palmetto, FL 34221 (941)-729-5516

Medical History/ Social History

Name:_____ Date Of Birth:____/_____/_____
Email:_____ Phone Number: _____ Can we text this #: ____
Address:_____
Are you Pregnant or Nursing? [ ]Yes [ ]No Are you Diabetic? [ ]Yes [ ]No
Have you had refractive surgery? [ ]Yes [ ]No
Are you Allergic to any medications? [ ] Yes [ ]No If yes, explain_____
List Current Medications OR Please Attach A List:

_____

List Major Injuries/Surgeries/Hospitalzations:

_____

List Any Eye Surgeries:

_____

Do you wear glasses [ ] Yes [ ]No Do you wear contact lenses [ ]Yes [ ] No If yes, what type: [ ]Soft [ ]Rigid
Your contact lens brand/Prescription:_____
Would you like to be fitted for contacts today? [ ]Yes [ ]No
Do you use, or have you ever used tobacco products? [ ]Yes[ ]No If yes, type/amount/how long?_____

Have you been exposed or infected with:

[ ] Gonorrhea	[ ] Hepatitis	[ ] HIV	[ ] Syphilis

Do you drink alcohol? [ ]Yes [ ]No If yes, how frequent?_____ Have you ever received a blood transfusion?____

Patient History/Review of Systems:

Cardiovascular [ ]Heart Disease [ ] Elevated Cholesterol [ ]High Blood Pressure	Lymphatic/ Hematologic [ ] Anemia [ ] Coagulation Disorder [ ] Leukemia	Musculoskeletal [ ] Arthritis [ ] Muscle Pain [ ] Joint Pain [ ] Rheumatoid Arthritis
Integumentary(Skin) [ ] Lupus [ ] Psoriasis [ ] Eczema	Gastrointestinal [ ] Diarrhea [ ] Constipation	Respiratory [ ] Asthma [ ]Bronchitis [ ]Emphysema
Psychiatric [ ]ADD/ADHD [ ] Anxiety [ ] Depression	Endocrine [ ] Diabetes Type I [ ] Diabetes Type 2 [ ] Thyroid Dysfun.	Neurologic [ ] Seizures [ ] Multiple Sclerosis [ ] Headaches/Migraines
Genitourinary [ ] Kidney Problems [ ] Bladder Problems Constitutional [ ] Diarrhea	Ears/Nose/Throat [ ] Chronic Cough [ ] Dry Mouth [ ] General Allergies [ ] Head Colds	Eyes [ ] Crossed Eye [ ] Lazy Eye [ ] Glaucoma [ ] Retinal Detachment

Family History

Ocular/Systemic Conditions	Please Write who In your Family Has the Condition Below
[ ] Blindness due to Disease [ ] Blindness due to Injury [ ] Glaucoma [ ] Macular Degeneration [ ] Cataracts [ ] Retinal Detachment [ ] Retinal Degeneration [ ] Arthritis [ ] Diabetes [ ] Heart Disease [ ] Hypertension [ ] Kidney Disorder [ ] Other	

Ocular History/Review of Systems

[ ] Blurry Vision [ ] Double Vision [ ] Dryness [ ] Redness [ ] Itchy [ ] Burning [ ] Eye Pain
[ ] Light Sensitivity [ ] Watery Eyes [ ] Tired Eyes [ ] Flashes [ ] Floaters

Manatee Family Eye Care
501 Village Green Parkway, S. 3 Bradenton, FL 34209 (941)-792-7522
319 7th St W. Palmetto, FL 34221 (941)-729-5516

[ ] Constipation		[ ] Cataract		

CONSENT OR REFUSAL FOR A DILATED FUNDUS EXAM

Possible side effects (these side effects typically do not last longer than 4-6 hours):

Reduced to focus at near, Increased sensitivity to light, some tearing and slight decrease vision are possible. Rare cases include redness, burning, and increased intraocular pressure. If these occur, contact our office. Most side effects last between 4-6 hours.

Please Check One Box:

I understand the above and consent to have dilation done.

- ☐ I understand the above and decline dilation at this time.
- ☐ I accept and approve that I can be dilated. I understand that potential for partial or total loss of vision may exist and, without dilation, may go undetected.

Signature:_____ Date:_____

MANATEE FAMILY EYE CARE PRIVACY POLICY AND HIPPA

Here at Manatee Family Eye Care, we will take the utmost care of your confidential records. The health information professionals have been trained to manage many of the systems required by HIPPA. Professionally, we are bound by a code of ethics to promote and protect the confidentiality and security of your medical records and health information. Our goal is to have patient's trust that their medical records and confidential information will remain private. Our health information professionals are committed to maintaining the privacy and quality of care.

I, the patient, sign below to give permission to the staff of Manatee Family Eye Care to give any of my medical information to these select few people.

- ❑ My Primary Care Physician _____
  Phone Number:_____
- ❑ Name:_____
  Relationship:_____ Phone Number:_____
- ❑ Name:_____
  Relationship:_____ Phone Number:_____
- ❑ Name:_____
  Relationship:_____ Phone Number:_____
- ❑ Name:_____
  Relationship:_____ Phone Number:_____

Signature:_____ Date:_____

INSURANCE

The Manatee Family Eye Care staff will be taking any Medical and Vision Insurance cards that you may have to ensure that your insurance will be billed for the visit. That being said, it is at your insurance company's discretion that they cover any dollar amount of the visit.

I, the patient, sign below to accept all responsibility of payment if my insurance does not pay for the entire amount of the office visit or examination of the current and any future visits at Manatee Family Eye Care.

Signature:_____ Date:_____