Welcome To Visioncare Family!

Please FAX or EMAIL this form BEFORE your appointment!

Fax: 954-434-2104 or scan/email: info@visioncarefamily.com

☐Mr. ☐Mrs. ☐Ms. ☐Miss. ☐Dr.

Last Name: _____ First Name_____ DOB_____

Address: _____ City_____ State_____ Zip _____

Home phone: _____Work _____ Cell _____

Employer (School) _____ Social Sec #_____

MEDICAL Insurance Name: _____ ID # _____

Main Member (if different from above) Name_____ SS#_____ DOB_____

E-mail: _____

(All addresses are for office use only. We are now making greater use of e-mail communication).

Referred by? ☐ Established Patient ☐ Insurance ☐ Walked in

☐ by my Doctor _____ ☐ by my Friend/Family_____

Medical Health

Medications (include Over the Counter)	**dosage / how many times a day**	**Condition that you are treating**	**Year of diagnosis**

Are you currently pregnant or nursing? YES ☐ NO ☐

Write any **DRUG ALLERGIES**: _____

List ALL **Surgeries** and **YEAR**: _____

_____

Medical History

Last Medical Exam_____ Name of Physician_____

Physician Address: _____

Physician's Phone# _____ Fax#_____

Please Circle history of your systemic diseases: present or past

Vascular: ☐Chest pain ☐High blood pressure ☐Cholesterol ☐Heart disease ☐Stroke ☐Arrythmia ☐Murmur

Constitutional: ☐Weight gain ☐Weight loss ☐Nausea ☐Constipation ☐Vomit ☐Diarrhea ☐Fatigue ☐Fainting

Endocrine: ☐Diabetes ☐Diabetes Suspect ☐Thyroid dz ☐Gout ☐Crohn's ☐Pituitary dz

Gastrointestinal: ☐Acid Reflux ☐Gallbladder ☐Ulcer ☐Stomach/Colon cancer ☐Cirrhosis ☐Liver dz

Genitourinary: ☐Menopause ☐Kidney stones ☐Bladder infections ☐Impotence ☐Ovarian cysts ☐Prostate dz

Ear/Nose/Throat: ☐Sinusitis ☐Post Nasal Drip ☐Hearing Loss ☐Dry Mouth ☐Ear Infections

Hematological/ Lymphatic: ☐Anemia ☐Bleeding dz ☐Hodgkin's ☐Sickle Cell ☐Varicose ☐Breast Cancer

Immunological: ☐HIV ☐Aids ☐Herpes simplex ☐Herpes zoster ☐Sjogren's ☐Lyme dz ☐Mononucleosis

Skin: ☐Acne ☐Psoriasis ☐Dermatitis ☐Hair Loss ☐Acne Rosacea ☐Urticaria ☐Impetigo ☐Lupus

Musculoskeletal: ☐Arthritis ☐Osteoporosis ☐Joint Pain ☐Scoliosis ☐Paget's ☐Ankylosis Spondilitis ☐Down's

Neurological: ☐Headaches ☐Seizure ☐Parkinson ☐MS ☐Nystagmus ☐Vertigo ☐Bell's Palsy ☐Epilepsy ☐Dyslexia

Psychiatric: ☐Depression ☐Anxiety ☐ADD ☐Bipolar ☐Insomnia ☐Alzheimer's ☐Autism ☐Mentally Challenged

Respiratory: ☐Asthma ☐Bronchitis? ☐COPD ☐Emphysema ☐Lung cancer ☐Sarcoidosis ☐TB ☐Pneumonia

Other:

Eye Health/Eyeglasses

Date of last EYE exam _____ Name of last EYE doctor _____

Check if you have or had any of the following eye problems?

- ☐ Itching/mucous
- ☐ Blurred vision with glasses
- ☐ Trouble seeing at night
- ☐ Eyestrain when reading
- ☐ Spots/Floaters
- ☐ Red/Gritty/Dry eyes
- ☐ Double Vision
- ☐ Tearing/Burning
- ☐ Lazy Eye
- ☐ Headaches
- ☐ Infection/yellow mucous
- ☐ Eye Surgery: Lasik, RK
- ☐ Eye Injury
- ☐ Retinal Detachment
- ☐ Macular Degeneration
- ☐ Cataracts

What do you like **LEAST** about your eyeglasses? _____

Contact Lenses

How often do you wear contacts? ☐Never ☐Everyday ☐2-4x a month ☐2-4x a year
How many nights do you sleep in your contacts? _____ How often do you throw them away? _____
What is the name brand of your contacts? _____ What is the prescription? R_____ L_____
What do you like **LEAST** about your contacts? _____

Occupation/ Social History:

Occupation _____ Hobbies:_____
How many **hours per day:** driving ___ outdoors___ using computers ___
In what type of activities do you participate on a weekly basis? Water sports, fishing, boating, walking/running, gym, Basketball, football, soccer, baseball, or other _____

How often do you **smoke**, or use **tobacco**?	☐Never	☐Former	☐<1pk/day	☐ Tobacco	
Former Smokers: When did you quit?	☐<1yr ago	☐1-2yr ago	☐3-4yr ago	☐4-5yr ago	☐5+ ago
How often do you drink **alcohol**?	☐Never	☐Social Use	☐1-2 drinks daily	☐>2drinks daily	
Do you use **illegal drugs**?	☐None	☐Recreational	☐Chemical Dependence		
Do you have any **Sexually Transmitted Disease**	☐None	☐Yes	☐HIV		

Family History

Which family members (Mom, Dad, Sister, Brother, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather, or NONE) have the following diseases?

Systemic Health	Ocular Health
Diabetes:	Glaucoma:
Cancer:	Macular Degeneration:
Heart disease:	Crossed Eyes:
	Retinal Detachment:

Authorization

I request that payment of authorized Insurance Benefits be made on my behalf to Dr. Cristina Sicoia for any services furnished me, or my dependents. I authorize any holder of medical information about me, to release to the health care financing administration and its agents, any information need to determine these benefits or the benefits payable for related services

Changes to HIPPAA Notice: We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be available to view in our facility. Copies of this Notice are also available upon request at our reception area. Notice Revised and Effective: August 30, 2013

ACKNOWLEDGEMENT RECEIPT: I acknowledge that I received or read a copy of Cristina Sicoia O.D., Notice of Privacy Practices.

Patient Name (Print) _____ Date _____

Patient or Guardian Signature (Sign)_____