Patient Forms

Dr Brad Cook OD
2332 Hwy 44 W
Inverness, Fl 34453
352-726-2085
glasses2day.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 ____________________

Citrus Vision
Dr Brad Cook OD
2332 Hwy 44 West
Inverness, FL 34453
352-726-2085
info@citruseye.com

CITRUS VISION
TRUSTED EYE CARE SINCE 1965

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: Citrus Vision Fax:352-726-2738 Phone: 352-726-2085

Signed_________________________________ Date__________________________