

CENTRAL FLORIDA EYE CENTER, P.A.
 KENNETH GATSON, O.D. ♦ KRISTINE VERKAIK, O.D.
 Board Certified Optometric Physicians
 WELCOME TO THE OFFICE - ACQUAINTANCE FORM

Personal Information

Name _____ Today's Date ____ / ____ / ____
 If Youth, Parents' Name _____
 Address _____
 City _____ State _____ ZIP _____
 Occupation _____
 Marital Status _____
 Daytime/Cell Phone# _____ Home Ph# _____ E-Mail _____
 Birth Date ____ / ____ / ____ Social Security # ____ - ____ - ____ Sex M F Race ____
 May we thank someone for referring you to us? _____
 Would you like us to notify you when it is time to have your eyes reexamined? Yes No

Ocular History

Have you had any eye injury or disease? No Yes If yes, please explain:

 Date of last eye exam _____ By whom? _____
 Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____
 Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? _____

Have your eyes ever given you a problem in the following areas:

Check here if **NO** to all

	No	Yes		No	Yes
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>
Twitching	<input type="checkbox"/>	<input type="checkbox"/>			

Family and Social History

Are there any serious eye disorders in your family? _____
 (i.e., blindness, crossed eyes, glaucoma, macular degeneration)

Do you use tobacco products? No Yes
 Do you drink alcohol? No Yes If yes, do you drink more than 2 drinks daily? No Yes
 Do you use any other substances? No Yes If yes, type/amount/how long? _____

Medical History

Name of Medical Doctor _____ Last Medical Exam ____ / ____ / ____
 Please list all medicines you are presently taking (Check here if you take no medicines) _____

*Please turn this form over and complete the other side *

Review of Systems

Do you currently or have you ever had any problems in the following areas? (If yes, please explain & list medications)

Check here if **NO** to all

SYSTEM	NO	YES	?	EXPLAIN
CONSTITUTIONAL (fever, weight loss/gain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
INTEGUMENTARY (skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
NEUROLOGICAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
EARS, NOSE, MOUTH THROAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
RESPIRATORY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
VASCULAR/CARDIOVASCULAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GASTROINTESTINAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
GENITOURINARY (genitals/kidney/bladder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
BONES/JOINTS/MUSCLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
LYMPHATIC/HEMATOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ENDOCRINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have any allergies to medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER MED. CONDITIONS ie HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Insurance Information

If you would like us to submit an insurance claim for you, list each insurance and sign lifetime authorization: I request that payment of authorized insurance benefits be made on my behalf to Central Florida Eye Center, P.A. I authorize Dr. Gatson/Verkaik to release information about me to the insurance company and its agents to determine benefits for related services.

Name of Insurance Company	ID #	Patient lifetime authorization signature
_____	_____	_____
_____	_____	_____
_____	_____	_____

Notice of our Privacy Practices (Please take a copy of attached “Notice of Privacy Practices”)

I acknowledge that I received a copy of Dr. Gatson/Verkaik “Notice of Privacy Practices” _____

(Please Initial)