SUNNY ISLES
EYE CENTER

Marina Yagudaev, O.D.

Welcome To Sunny Isles Eye Center

Please complete this form and bring it to your appointment so that we may provide you with a more comprehensive and personalized level of care. Thank you!

Today's Date: ____/_____/202___

PATIENT INFORMATION

Patient Last Name: _____ First name: _____ Age: _____

Date of Birth: ____/____/_____ Sex F ☐ M ☐ SSN last 4-____ Parent or Guardian Name: _____

Phone: (c): _____ (h):_____ Email: _____

Address: _____ Apt:_____ City: _____ State:_____ Zip: _____

Type of Payment: Credit Card ☐ Cash ☐ Insurance ☐ Type: _____

Reason(s) for Today's Visit:_____

Do you wear glasses? yes ☐ no ☐ / Distance: ☐ Near: ☐ Both:☐

Do you wear Contact Lenses: yes ☐ no ☐ If yes what type: _____
Are you interested in Contact Lenses: yes ☐ no ☐

How many hours a day do you use a computer/smart devise? _____ Occupation_____

Last eye exam: ___/___/____ Doctor: _____ Your Last Physical Exam: ___/___/____Doctor: _____

Do you smoke? yes ☐ no ☐ How many packs a day? _____
Do you use alcohol? yes ☐ no ☐ How often?_____

Do you take any Eye Drops: _____

Do you take any medications: yes ☐ no ☐

Please list all medications/dose and reasons:

_____

_____

_____

Are you allergic to any medications/food: yes ☐ no ☐_____

Your Pharmacy's Name: _____ Address: _____Zip:_____
Phone: _____

EYE HEALTH HISTORY/HISTORY OF PRESENT ILLNESS (HPI)

Please mark ALL conditions that you have experienced in the recent past:

Ocular Complaints:

- ☐ Double Vision
- ☐ Flashes
- ☐ Floaters
- ☐ Headaches

Vision Loss:

- ☐ Any Vision Loss

Vision Complaints:

- ☐ Distance Blurry
- ☐ Near Blurry
- ☐ Computer Blurry

Ocular Symptoms:

- ☐ Eye Fatigue
- ☐ Pain
- ☐ Dry, sandy feeling
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Watery Eyes
- ☐ Photophobia/Light Sensitivity

Contact Lenses:

- ☐ Excessive Discomfort
- ☐ Dryness
- ☐ Lens Movement
- ☐ Fogging

Other: _____

OCULAR HISTORY & OCULAR FAMILY HISTORY:

Please indicate if ANY of the conditions apply to you or a blood relative:

	YOU	FAMILY		YOU	FAMILY
Bell's Palsy	☐	☐	Keratoconus	☐	☐
Cataract	☐	☐	Lazy Eye	☐	☐
Chalazion/Styes	☐	☐	Macular	☐	☐
Eye infection	☐	☐	Degeneration	☐	☐
Eye Turn	☐	☐	Optic Neuritis	☐	☐
Glaucoma	☐	☐	Retinal Disease	☐	☐
Iritis	☐	☐	Trauma, Ocular	☐	☐

Other ocular history, please list: _____

Eye Surgeries (type & year): _____

Other Surgeries (type & year): _____

SYSTEMIC FAMILY HISTORY/REVIEW OF SYSTEMS:

Cardiovascular Disease	☐	☐	Headaches	☐	☐	Pregnant	☐	
Elevated Cholesterol	☐	☐	Meniere's Syndrome	☐	☐	Nursing	☐	☐
Hypertension	☐	☐	Sinusitis	☐	☐		☐	☐
Stroke	☐	☐	Hematologic Disorder	☐	☐			
			Sickle Cell	☐	☐			
Anemia	☐					Sarcoidosis	☐	☐
Blackouts	☐	☐	AIDS	☐	☐	Lung Cancer	☐	☐
Dizziness	☐	☐	HIV	☐	☐	Asthma	☐	☐
			Sjogren's Syndrome	☐	☐			
Diabetes Mellitus	☐	☐				Alzheimer's Disease	☐	☐
Thyroid Disease	☐	☐	Acne Rosacea	☐	☐	Bi-polar Depression	☐	☐
Renal Disease	☐	☐	Lupus	☐	☐	Anxiety Disorder	☐	☐
			Psoriasis	☐	☐			
Colitis	☐	☐	Myasthenia Gravis			Parkinson's	☐	☐
Cancer Colon	☐	☐	Arthritis	☐	☐	Seizure	☐	☐
Ulcer, Stomach	☐	☐	Rheumatoid Arthritis	☐	☐	Multiple Sclerosis	☐	☐