Dr. Andrew Tran, OD & Dr. Van Mai Vu, OD
112 E. Dixie Ave, Leesburg, FL 34748

EYECARE CENTER OF LEESBURG

Date: _____

Patient Name: _____
Patient Nickname: _____
Date of Birth: ____/____/_____ Age _____ Sex: ❑ M ❑ F
Ethnicity: _____ SSN #: ____ - ___ - _____
Phone: _____
Pediatrician / Location: _____
_____
Eye Doctor / Location: _____
Preferred Pharmacy Location: _____
_____
Special Needs: ❑ Hearing Impaired ❑ Translator ❑ Wheelchair

Guardian's Name: _____
SSN#: ____ - ____ - _____
Relationship to Patient: _____
Address: _____
_____
Phone: H _____ W _____
C _____, Cell Carrier _____
Email: _____

I prefer to be contacted via... (check ONE)
❑ Email ❑ Home phone ❑ Work phone ❑ Cell ❑ Text ❑ Mail

Insurance Information

Primary Insurance Carrier _____ ID / Policy / Group # _____ Insured's Name _____

Secondary Insurance Carrier _____ ID / Policy / Group # _____ Insured's Name _____

Vision Service Plan or VCP Comp Benefits or Eyemed

Member's Name _____ Member's ID _____ Member's Birthdate _____

Member's Relationship to Patient: ❑ Parent ❑ Self ❑ Spouse ❑ Child ❑ Domestic Partner

Notices & Authorizations

1. Shared Medical Information Authorization

I authorize the Eyecare Center of Leesburg (ECoL) to share my medical records with the persons named below from the date signed until I provide the ECoL written notice to cease.

Emergency Contact: _____ P: (____) ____-____

❑ Others: _____

Signature _____

Date _____

2. Notice of Privacy Practices, HIPAA Acknowledgement (Copy given upon request)

I have read the Eyecare Center of Leesburg (ECoL) Notice of Privacy Practices and understand my rights contained therein. By way of my signature I acknowledge that the ECoL has provided me with a policy regarding the use and disclosure of my protected healthcare information for the purposes of treatment, and healthcare operations as described in the Notice of Privacy Practices.

Signature _____

Date _____

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Patient's (okay to estimate):
Last Eye Exam _____ Last Physical Exam _____ Height: _____ Weight: _____

What is the main reason for your visit?
Select ONE: ❑ Annual checkup ❑ Glasses/CL update ❑ Blurry vision ❑ Red eye/s ❑ Double vision ❑ Flashes / Floaters
❑ My child failed their vision screening with their school / pediatrician ❑ Other_____

CURRENT EYE / VISION PROBLEMS

❑ Blurry vision	❑ Eye turns in / out	❑ Double vision	❑ Headaches
❑ Red eye	❑ Itchy eyes / eye rubbing	❑ Tired eyes / eye strain	❑Losing place when reading
❑ Squinting	Any other visual symptoms or eye problems not listed? _____		

COMPUTER / VIDEO GAME USE
When using devices are the following symptoms experienced?

❑ Tired eyes	❑ Dry eyes	❑ Headaches	❑ Blurred vision
❑ Double vision	❑ Red eyes	❑ Other: _____	

EDUCATIONAL HISTORY
Current Grade: _____ Has your child ever repeated a grade? ❑ No If yes, which one(s)? _____

Does your child receive any special services from school? ❑ No If yes, indicate type and how often?
(e.g. speech, language, occupational therapy, reading remediation) _____
_____

Does your child like school?	❑ Yes	❑ No
Is your child performing at his/her potential at school?	❑ Yes	❑ No
Is your teacher satisfied with your child's school performance?	❑ Yes	❑ No
Is your child in the grade level expected for his/her age?	❑ Yes	❑ No
Does your child read as well as others in the same grade?	❑ Yes	❑ No

Medications (Please include prescription & over the counter medications, eye drops, contraceptives & supplements)
❑ Please check here if you have brought your own attached list of medications

Name	Dose & SIG (How Often)	Purpose (Used for)

Allergies ❑ Please check here if you have brought your own attached list of allergies

Patient is allergic to…	Allergic reaction to this is….			
_____	❑ Anaphylaxis	❑ Hives/rash	❑ Swelling	❑ Other: _____
_____	❑ Anaphylaxis	❑ Hives/rash	❑ Swelling	❑ Other: _____
_____	❑ Anaphylaxis	❑ Hives/rash	❑ Swelling	❑ Other: _____
_____	❑ Anaphylaxis	❑ Hives/rash	❑ Swelling	❑ Other: _____
_____	❑ Anaphylaxis	❑ Hives/rash	❑ Swelling	❑ Other: _____

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DEVELOPMENTAL HISTORY

Child's birth weight: _____

Were there any complications with pregnancy or at birth? ❑ No If Yes, please explain: _____

Was your child born premature? ❑ No If Yes, what was the length of pregnancy? _____wks

Was there any use of alcohol, drugs, medication, or cigarettes during the pregnancy? ❑ No If Yes, please explain: _____

Please complete and CHECK ALL THAT APPLY

1. Glasses None ❑
Patient wears glasses ❑ Full time ❑ Distance only ❑ Reading only ❑ Sports / Specialty ❑ As needed

2. Contact Lenses None ❑
Name of current contacts: _____
Used for ❑ Full time ❑ Part time ❑ Myopia Control ❑ Sports ❑ Discontinued

3. Visual demands
Patient uses vision for ❑ Card play ❑ Golfing ❑ Crafting ❑ Fishing ❑ Shooting ❑ Other _____
On an average day patient uses the computer / cell phone / tablet / etc.: ❑ < 2 hrs ❑ 2-6 hrs ❑ > 6 hrs

4. Family Medical History None ❑
As far as I am aware, in the family (grandparents, parents, siblings, children) there has been…
❑ Glaucoma ❑ Keratoconus ❑ Night blindness ❑ Eye turn ❑ Macular degeneration ❑ Migraines
❑ Diabetes ❑ Hypertension ❑ Heart disease ❑ Cancer ❑ Other _____

Patient has diagnosed…
❑ Glaucoma ❑ Macular degeneration ❑ Eye turn ❑ Keratoconus ❑ Amblyopia ❑ Uveitis
❑ Trauma ❑ Diabetic Retinopathy ❑ Other: _____

5. Personal Eye History None ❑
Patient had surgery for: ❑ Cataract Surgery RE ___/___/___, LE ___/___/___
(include approximate date) ❑ Retinal Detachment Surgery RE ___/___/___, LE ___/___/___

Patient has diagnosed… None ❑

6. Personal Medical History
Cardiovascular: ❑ High Cholesterol ❑ Hypertension ❑ Heart disease ❑ Heart attack / stroke
Respiratory: ❑ Sleep Apnea ❑ Asthma / COPD
Endocrine: ❑ Diabetes Type__, HbA1 ____% ___/___/___, FBS / RBS _____ mg/dl
❑ Cancer: _____
❑ Other Conditions: _____
All Other Surgeries: _____

Patient is currently experiencing the following symptoms None ❑

7. Personal Review of Systems

Constitutional	❑ Unexplained fever / weight loss / fatigue
Cardiovascular	❑ Chest pain ❑ Irregular heartbeat ❑ Shortness of breath ❑ Hypertension
Ears/Nose/Throat	❑ Loss of smell ❑ Sinus congestion ❑ Hearing loss ❑ Sore throat / hoarse voice
Respiratory	❑ Shortness of breath ❑ Wheezing sounds ❑ Persistent cough
Gastrointestinal	❑ Vomiting blood / blood in stool ❑ Constipation / diarrhea
Genitourinary	❑ Difficulty / burning while urinating
Musculoskeletal	❑ Joint pain / restriction of motion ❑ Unexplained muscle pain / lower back pain
Immunologic/skin	❑ Unexplained rashes / itching ❑ Pigmented lesion ❑ History of infectious disease
Neurologic	❑ Weakness / tingling in extremities ❑ Dizziness/black/grey outs
Psychiatric	❑ Memory lapses ❑ Disorientation ❑ Ongoing depression ❑ Dementia
Endocrine	❑ Increased urination / thirst / appetite
Hematologic	❑ Anemia / frequent bruising
Lymphatic	❑ Swollen glands
Allergies	❑ Seasonal ❑ Penicillin ❑ Sulfa ❑Anesthetic ❑ Other _____
Other	Any other current symptoms: _____

8. Social History None ❑
❑ Patient uses or has used tobacco, alcohol, or narcotics or has a reported history of blood transfusions sexually transmitted disease (STD). Please explain: _____

9. Misc.
Patient is currently ❑ Pregnant ❑ Nursing

❑ I verify that all unchecked boxes in sections 1-9 are N/A.

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Convergence Insufficiency Symptom Survey **Binocular Vision Screener**

This Survey was developed by the Convergence Insufficiency Research Group

CISS SYMPTOM SURVEY

(for patients ≥ 8 years of age)

Please answer the following questions about how your eyes feel when reading or doing close work.
(For patients < 12 years of age, the parent should read the questions to the patient.)

Symptom	Never	Not Often	Some times	Fairly Often	Always
1. Do your eyes feel tired when reading or doing close work?	❑	❑ 1	❑ 2	❑ 3	❑ 4
2. Do your eyes feel uncomfortable when reading or doing close work?	❑	❑ 1	❑ 2	❑ 3	❑ 4
3. Do you have headaches when reading or doing close work?	❑	❑ 1	❑ 2	❑ 3	❑ 4
4. Do you feel sleepy when reading or doing close work?	❑	❑ 1	❑ 2	❑ 3	❑ 4
5. Do you lose concentration when reading or doing close work?	❑	❑ 1	❑ 2	❑ 3	❑ 4
6. Do you have trouble remembering what you have read?	❑	❑ 1	❑ 2	❑ 3	❑ 4
7. Do you have double vision when reading or doing close work?	❑	❑ 1	❑ 2	❑ 3	❑ 4
8. Do you see the words move, jump, swim, or appear to float on the page when reading or doing close work?	❑	❑ 1	❑ 2	❑ 3	❑ 4
9. Do you feel that you read slowly?	❑	❑ 1	❑ 2	❑ 3	❑ 4
10. Do your eyes ever hurt when reading or doing close work?	❑	❑ 1	❑ 2	❑ 3	❑ 4
11. Do your eyes ever feel sore when reading or doing close work?	❑	❑ 1	❑ 2	❑ 3	❑ 4
12. Do you have a “pulling” feeling around your eyes when reading or doing close work?	❑	❑ 1	❑ 2	❑ 3	❑ 4
13. Do words blur or come in and out of focus when reading or doing close work?	❑	❑ 1	❑ 2	❑ 3	❑ 4
14. Do you lose your place while reading or doing close work?	❑	❑ 1	❑ 2	❑ 3	❑ 4
15. Do you have to re-read the same line of words when reading?	❑	❑ 1	❑ 2	❑ 3	❑ 4

Add scores from each column: _____ _____ _____ _____

TOTAL SCORE: _____

How did you hear about our office?

Check all that apply: ❑ Doctor referral ❑ Friend or family recommendation ❑ Social Media ❑ Online Search ❑ Other _____