DATE: ___/___/_____

PATIENT INFORMATION

LAST NAME: ____________________ **FIRST NAME:** _______________________ **M F BIRTH DATE:** ____/____/____

ADDRESS: ____ **CITY:** _______________ **STATE:** ______ **ZIP:** ________

PREFERRED TELEPHONE # __(_____)______________ *HOME WORK CELL* **SECONDARY TELEPHONE #** __(_____)______________ *HOME WORK CELL*

EMPLOYER: _____________________ **OCCUPATION:**___________________ **MARITAL STATUS:** single married

REFERRED BY: ___________________ **EMAIL ADDRESS:** ______________________________ **ETHNICITY:** _______________

INSURANCE INFORMATION

VISION INSURANCE PLAN: ________________________________ **MEMBER ID#:** ____________________________

MEDICAL INSURANCE PLAN: ______________________________ **MEMBER ID#:** ____________________________

POLICY HOLDER'S NAME:__________________________**BIRTH DATE:** ____/____/____ **RELATIONSHIP TO PATIENT:** Self Spouse Parent/guardian

MEDICAL AND OCULAR HISTORY

WHAT IS THE REASON FOR TODAY'S EXAM?: ____

____

AGE OF GLASSES: ________ **DATE OF LAST EYE EXAM:** ________ **FROM DR.** _______________ **PREVIOUS PATIENT?** Yes / No

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENTS, PARENTS, BROTHER, SISTER) HAVE ANY OF THESE?

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE		YES	NO
DIABETES				**GLAUCOMA**				**DO YOU SEE DOUBLE?**		
HIGH BLOOD PRESSURE				**MACULAR DEGEN**				**FREQUENT HEADACHES?**		
THYROID CONDITION				**RETINAL DISEASE**				**ARE YOU PREGNANT?**		
HEART DISEASE				**EYE INJURY**				**LAST TIME EYES WERE DILATED?** _______		
HIGH CHOLESTEROL				**EYE SURGERY**				**PRIMARY CARE DR** __________________		
ASTHMA				**OTHER**				**SMOKING STATUS? Daily Sometimes Former Never**		

ARE YOU TAKING ANY EYE DROPS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST: ___________________________

____

ARE YOU TAKING ANY OTHER MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST: ____________________

____

DO YOU HAVE ANY ALLERGIES TO MEDICATION OR OTHER? IF YES, PLEASE EXPLAIN _________________________________

____

ARE YOU HAVING ANY PROBLEMS WITH YOUR VISION? Far Away Close Up In Between

WHAT TYPE OF WORK DO YOU DO? __________________ **HOW MANY HOURS PER DAY ARE YOU ON THE COMPUTER?** ___

DO YOUR EYES GET TIRED WHEN READING? Yes No **PROBLEMS WITH BRIGHT LIGHTS OR GLARE?** Yes No

WHAT TYPE OF SUN PROTECTION DO YOU CURRENTLY WEAR? ___________ **HAVE YOU WORN CONTACTS?** Yes No

ARE YOU PLANNING TO GET NEW CONTACT LENSES TODAY? Yes No Unsure

WHAT DO YOU LIKE/DISLIKE ABOUT YOUR CURRENT CONTACTS? Vision Comfort Dryness Color Itch

WHEN DO YOUR CONTACTS FEEL DRY? _______________ **HOW OFTEN DO YOU SLEEP WITH THEM?** _________________

DATE: ___/___/_____

INTERNAL EYE HEALTH ASSESSMENT

Our doctors not only care about your sight, but also the **health** of your eye. **Internal photography (Optomap) and/or dilation** are methods to check for and monitor for any progression of diseases such as **glaucoma, macular degeneration,** and **retinal detachment.** Common conditions such as **diabetes and high blood pressure** can cause damage to the **back of the eye (retina)** and can also be detected through these tests. It is **highly recommended** by the doctor to have **at least one** of these tests done at the annual eye exam.

☐ **Yes, I would like to have the Optomap performed for a $39 charge.** ***This is the preferred method to limit office wait time and patient-to-doctor exposure.*** This captures a comprehensive image of the retina in a few minutes that the doctor will review with you and keep in your record.

☐ **Yes, I would like the doctor to perform dilation,** where eye drops are put in the eye to allow a better view inside. Normal side effects of the eye drops are blurry vision close up and light-sensitivity that can last a few hours. There is an additional wait time of 20-30 minutes to allow drops to take effect and dilate the eyes.

☐ **No, I decline both dilation and Optomap.** I understand that this goes against the recommendation by our doctors.

The doctor may give additional recommendations based on their findings during the eye examination.

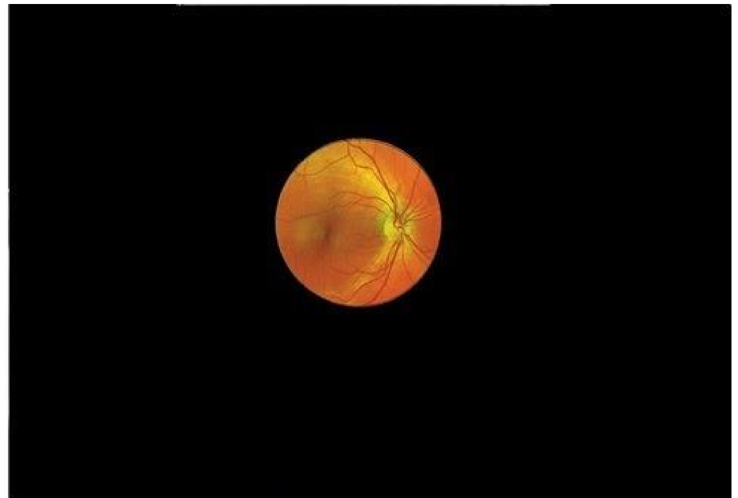
____ ____

Patient Name Signature of the patient (or guardian if under 18 years of age)

____

Date

optomap **Retinal Image**
82% view of the retina



Traditional View
15% view of the retina