WELCOME TO OUR OFFICE!

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

Please Print

Date _____

Patient's Full Legal Name _____

DOB ____/____/____ SSN# ____/____/____

Address _____

City/St _____ Zip _____ Country _____

Type of Address ❑ Home ❑ Office

Home Phone _____

Cell Phone _____

Work Phone _____

Email _____

Note: It is now required we obtain an email address so we can upload your visit to the patient portal

Marital Status ❑ M ❑ S ❑ D ❑ W

Spouses Name _____

DOB ____/____/____ SSN# ____/____/____

Primary Language ❑ English ❑ Spanish ❑ Other

Special Needs: ❑ Hearing Impaired ❑ Translator ❑ Wheelchair

Race ❑ White ❑ African American ❑ Asian

❑ Other _____ ❑ Decline to Answer

Ethnicity ❑ Hispanic or Latino ❑ Non-Hispanic or Latino

❑ Unknown ❑ Decline to Answer

Employer _____ Occupation _____

Last PCP Visit ____/____/____ PCP Doctor _____

Last Eye Exam ____/____/____

Prev. Eye Dr. _____

Miscellaneous

List any previous surgeries with dates

_____

_____

_____

Are You Pregnant? ❑ Yes ❑ No

Are You Breastfeeding? ❑ Yes ❑ No

Hobbies/Recreational Sports you enjoy _____

_____

_____

How many hours per day do you use a computer? _____

Do you wear glasses? ❑ Yes ❑ No

Do you wear contact lenses? ❑ Yes ❑ No

Are you interested in contact lenses? ❑ Yes ❑ No

Are you interested in refractive surgery? ❑ Yes ❑ No

Do you perform fine or close-up work? ❑ Yes ❑ No

Are you outdoors all or part of the time? ❑ Yes ❑ No

Do you have trouble reading signs when driving at night? ❑ Yes ❑ No

Are you bothered by glare from: Overhead lighting? ❑ Yes ❑ No

A computer screen? ❑ Yes ❑ No

Oncoming headlights at night? ❑ Yes ❑ No

Are you sensitive in bright sunlight? ❑ Yes ❑ No

Review of Systems

Do you currently have, or have you ever had, any of the following problems or conditions?

	Yes	No
Constitutional		
Fever, Weight Loss/Gain	❑	❑
Cardiovascular		
Heart Disease	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Stroke	❑	❑
Vascular Disease	❑	❑
Ears/Nose/Mouth/Throat		
Allergies	❑	❑
Sinus Congestion	❑	❑
Post Nasal Drip	❑	❑
Chronic Cough	❑	❑
Dry Mouth/Throat	❑	❑
Respiratory		
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Emphysema	❑	❑
Sleep Apnea	❑	❑

	Yes	No
Gastrointestinal		
Constipation	❑	❑
Crohn's Disease	❑	❑
Hepatitis A	❑	❑
Hepatitis B	❑	❑
Hepatitis C	❑	❑
Ulcer / Reflux	❑	❑
Genito-Urinary		
Bladder / Genital / Kidney	❑	❑
Herpes Simplex	❑	❑
Prostate	❑	❑
Musculoskeletal		
Joint / Muscle Pain	❑	❑
Osteo Arthritis	❑	❑
Rheumatoid Arthritis	❑	❑
Integumentary (skin)		
Skin Cancer	❑	❑
Skin Disease	❑	❑
Herpes Zoster/Shingles	❑	❑

	Yes	No
Neurological		
Headaches	❑	❑
Migraines	❑	❑
Multiple Sclerosis	❑	❑
Gout	❑	❑
Seizures	❑	❑
Psychiatric		
Anxiety / Depression	❑	❑
Endocrine		
Diabetes Type I	❑	❑
Diabetes Type II	❑	❑
Thyroid/Other Glands	❑	❑
Lymphatic – Hematologic		
Anemia	❑	❑
Bleeding Problems	❑	❑
Allergic / Immunologic		
Eczema	❑	❑
Hives	❑	❑
Lupus	❑	❑
Organ transplant	❑	❑

Please check if you have had any of the following medical conditions:

__High Blood Pressure __Thyroid Disease __High Cholesterol __Tuberculosis __Headaches/Migraines
__Diabetes __Arthritis __Hepatitis __Asthma __Heart Disease
__Cancer __Multiple Sclerosis __Allergies/Sinusitus __Pregnant__ Months Other _____

Please list all medications you are currently using, **including** over the counter medications:

_____ _____ _____
_____ _____ _____

Please list any allergies: _____ _____ _____

Please list any previous medical and ocular injuries/surgeries: _____

FAMILY HISTORY (please check all that applies to your immediate family members)

__Glaucoma __Amblyopia, Lazy Eye __High Blood Pressure __High Cholesterol __Multiple Sclerosis
__Macular Degeneration __Blindness __Diabetes __Thyroid Disease __Lupus
__Cataracts __Retinal Disease __Heart Disease __Cancer __Other _____

SOCIAL HISTORY

Current occupation: _____ Hobbies: _____
Do you drink alcohol? Yes__ No ___ if yes, how often and quantity: _____
Do you use tobacco products? Yes___ No ___ if yes, what kind and how much each day: _____

FUNDUS PHOTO

The word "fundus" describes the inside or back of the eyeball. A fundus photo would contain an image of the center of the very back inner wall of the eye: the retina. The optic nerve, macula and main retinal blood vessels are common structures seen in a fundus photo. Fundus photography is very useful to document the natural state of the back of the eye in order to give the retinal specialist a future reference to compare with during follow-up visits. It is important to document the findings of most retinal diseases and conditions, especially diabetic eye disease findings, macular degeneration, epi-retinal membranes, macular holes and retinal tears and detachment.

******The fee for this procedure is **$25.00** Please check one and sign below, **This procedure is not covered by insurance.**

_____ **I DO** consent to having fundus photos performed.

_____ **I DO NOT** wish to have fundus photos performed. I release my doctor from any liability of failure to treat, or diagnose any eye condition due to lack of diagnostic information that could have been obtained by this test.

DILATED EXAMINATION

Dilation is the process of administering special pharmaceutical eye drops into the eyes in order to enlarge the pupils. **This procedure will require an additional 20-30 minutes on top of normal exam time to complete.** This allows a more thorough examination the structures of the eyes. Dilation is a key component of a comprehensive eye examination, as it sometimes leads to the detection and diagnosis of certain eye diseases and conditions such as: diabetes, eye tumors, high blood pressure, Infectious diseases, macular degeneration, retinal detachment and many more. Your near vision will be impaired with this procedure and you will also be light sensitive for approximately 4-6 hours. **This procedure is covered under insurance.**

- O Yes, I consent to have the dilated exam.
- O NO, I decline to have the dilated exam. I am aware of the risks associated with the failure to detect any eye conditions due to the lack of information that could have been obtained by this important procedure.

Patient/Guardian signature _____ Date: _____