Name____**DOB**_________________________

Address____ Cell Phone _____________________________

City/St/Zip______________________________________ Work Phone__________________ Home Phone_______________________

Email Address: ____Occupation: ____

Methods of Communication: Text Email Phone Social Security #____

Insurance: Vision________________________________Health______________________________ Supplement__________________

_____I want a contact lens exam. ______I want an eyeglass exam. _____I have dry eye, red eye or injury.

Review of Systems: Do you currently, or have you ever had any problems in the following areas? Please circle.

Eyes	**Constitutional**	**Neurological**
Blurred Vision	Allergies/Hay Fever	Headaches
Tired Eyes	Sinus Congestion	Migraines
Dryness	Runny Nose	Seizures
Itching	Post Nasal Drip	Stroke
Redness	Chronic Cough	**Genitourinary**
Sandy or Gritty Feeling	Dry Mouth/Throat	Genitals/Kidneys/Bladder
Burning	Diarrhea	Constitutional
Mucous Discharge	Constipation	Fever/Weight Loss/Gain
Excessive Tearing/Watering	**Vascular/Cardiovascular**	**Bones/Joints/Muscles**
Foreign Body Sensation	Diabetes	Rheumatoid Arthritis
Glare/Light Sensitivity	Heart Pain	Muscle Pain
Eye Pain or Soreness	High Blood Pressure	Joint Pain
Chronic Infection of Eye or Lid	Vascular Disease	**Lymphatic / Hematologic**
Sties or Chalazion	**Respiratory**	Anemia
Flashes/Floaters in Vision	Asthma	Bleeding Disorder
Distorted Vision	Chronic Bronchitis	Endocrine (Glands)
Loss of Side Vision	Emphysema	Thyroid
Double Vision		
Loss of Vision		

If you answered yes to any of the above or have a condition not listed and need more space for explanation:

____

____

Pupillary Dilation is the use of medicine drops to temporarily increase the size of the pupil. These drops will also temporarily change focus from one distance to another, mainly near vision. The dilation allows the pupil to enlarge resulting in better view of the eye. Near vision will be blurred for 2-3 hours **(Most insurances cover this test)**. I understand the risks and benefits of pupillary dilation.

I give consent to be dilated. Yes No FEE: $15

Overall Health Scan is now being offered in our office. This new health scan allows the doctor to detect early health issues such as: diabetes, glaucoma, stroke, macular degeneration and other circulatory disorders (This scan is not filed on health insurance).

I give my consent for the Health Scan. Yes No FEE: $35

Do you wear eyeglasses? Yes No
Do you wear prescription sunglasses? Yes No
Do you wear computer desk glasses? Yes No
Do you wear contact lenses? Yes No Daily Bi-weekly Monthly Yearly (gas permeable)
Wear time ________ hours a day ________ days a month

Signature of Patient: ____Date_____________________________

Signature of Patient Representative: ____ Date_____________________________

Medical History:

List Medications that you are presently taking____
____
____

Medication Allergies____
____
____

Family History:

Yes	No	Disease/Condition	Relationship to You
Yes	No	Blindness	________________________
Yes	No	Cataract	________________________
Yes	No	Crossed Eyes	________________________
Yes	No	Glaucoma	________________________
Yes	No	Macular Degeneration	________________________
Yes	No	Retinal Detachment/Disease	________________________
Yes	No	Arthritis	________________________
Yes	No	Cancer	________________________
Yes	No	Diabetes	________________________
Yes	No	Heart Disease	________________________
Yes	No	High Blood Pressure	________________________
Yes	No	Kidney Disease	________________________
Yes	No	Lupus	________________________
Yes	No	Stroke	________________________

Social History: This is kept confidential. However, you may discuss this directly with the doctor if you prefer.
Do you drive? Yes No
Do you have visual difficulty when driving? Yes No
Do you use tobacco products? Yes No If yes, what type ____________________How long? _________
Do you drink alcohol? Yes No
Do you use illegal drugs? Yes No Or overuse prescription drugs? Yes No
Have your ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis Other: ______________

Patient Consent of Private Health Information
I, the undersigned, authorize the release of medical and other information necessary for the treatment, payment and health care operations in accordance with the Privacy Policy of this office. We respect our legal obligation to keep health information that identifies you and your family private.

Signature of Patient____Date____________________________

Signature of Patient Representative____________________________________Date____________________________