Welcome to our office!

PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE AND RETURN IT TO THE DESK.

Name ____________ Today's Date ____________

Parent/Guardian ____________ Email Address ____________

Address ____________ Home Phone ____________

Apt. # ____________ ___Male ___Female Work Phone ____________

City ____________ State ______ Zip ______ Cell Phone ____________

Employer/Occupation ____________ Primary Care Doctor ____________

Years since last exam: __1 __2 __3+ Date of Birth ____________ Referred By ____________

Personal History

Allergies	Occular History	☐ Pregnant ☐ Wear Glasses ☐ Wear Contacts ☐ Soft ☐ Hard ☐They are comfortable
Medications	Injuries/Surgeries	

Family History: *Note relation to yourself in the box (example: Mother, paternal grandfather, etc.)*

☐ Blindness		☐ Cancer	
☐ Cataracts		☐ Diabetes	
☐ Macular Degeneration		☐ Heart Disease	
☐ Glaucoma		☐ High Blood Pressure	
☐ Retinal Detachment		☐ Kidney Disease	
☐ Crossed Eyes		☐ Arthritis	
☐ Lupus		☐ Thyroid Disease	

Other: ____________

Social History

☐ Doesn't Drive ☐ Drives
Explain Driving Difficulties

☐ Doesn't Use Tobacco ☐ Uses Tobacco
Type/Amount/How Long

☐ Doesn't Drink Alcohol ☐ Drinks Alcohol
Type/Amount/How Long

☐ No use of illegal Drugs ☐ Use of Illegal Drugs
Type/Amount/How Long

I am here for: ☐ Routine Eye Exam ☐ Glasses ☐ Contact Lenses ☐ Eye infection/injury ☐ Other: ________________

Review of Systems: *Please check all that apply*

Eyes
- ☐ Vision Loss
- ☐ Blurry Vision
- ☐ Distorted Vision
- ☐ Double Vision
- ☐ Dryness
- ☐ Redness
- ☐ Mucous Discharge
- ☐ Gritty Feeling
- ☐ Itching
- ☐ Burning
- ☐ Excess Watering
- ☐ Light Sensitivity
- ☐ Eye Pain/Soreness
- ☐ Chronic Infection
- ☐ Sties
- ☐ Flashes
- ☐ Floating Spots
- ☐ Tired Eyes
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Lazy Eye

Genitourinary
- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ STD's

Gastrointestinal
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Ulcers
- ☐ Constipation
- ☐ Diarrhea

Constitutional
- ☐ Fever
- ☐ Weight loss/gain
- ☐ Fatigue
- ☐ Trauma

Skin
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis

Neurologic
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Mult. Sclerosis

Endocrine
- ☐ Non-Insulin Diabetes
- ☐ Insulin Diabetes
- ☐ Thyroid Dysfunction

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema

Cardiovascular
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Hypercholesterolemia

Ear/Nose/Throat
- ☐ Allergies
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post Nasal Drip
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth

Allergic/Immune
- ☐ Drug Allergies
- ☐ Seasonal Allergies
- ☐ Lupus
- ☐ Arthritis

Lymphatic/Hematologic
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Leukemia

Musculoskeletal
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spond.

Pupil Dilation

Pupil dilation with eye drops allows the doctor to examine the peripheral retina for bleeding, tears, holes, detachments and other problems that may otherwise go undetected. Dilation generally is not necessary to check for cataracts, glaucoma, macular degeneration or to determine the prescription for glasses. It takes about 15 minutes for the pupils to dilate and about 5 minutes to evaluate the retina. Effects last 4-6 hours and include increased glare, light sensitivity and reduced near-focus ability. Although your distance vision will be affected the least, some patients do not like to drive while dilated. Dilation is an additional charge of $10.00.

☐ Yes, I want my pupils dilated today. ☐ No, I do not want dilation. ☐ I want to return later for dilation.

X____

Signature of patient or responsible party **Date**

REVISED 3.21.11