PATIENT HISTORY

Date_____

Name_____ Date of Birth_____
Address_____ City/State_____ Zip_____
Home Phone_____ Work_____ Mobile_____
Employer/Occupation_____ Health Insurance_____
Email_____ Vision Insurance_____
How did you hear about us?_____

VISUAL & MEDICAL HISTORY

Reason for today's exam_____
Contact lens type_____ Disinfection type_____
Who is your family doctor_____ Phone_____
Do you: use tobacco Y N If yes, type/amount/how long_____
drink alcohol Y N If yes, type/amount/how long_____
use illegal drugs Y N If yes, type/amount/how long_____
Have you ever been exposed to/infected with: ____Gonorrhea ____Hepatitis ____HIV ____Syphilis

Please circle each. Do you or your family have any of the following:

No	Retinal detachment	Yes, who_____	No	Blindness	Yes, who_____
No	Eye surgery	Yes, who_____	No	Head/Eye Injury	Yes, who_____
No	Glaucoma	Yes, who_____	No	Double Vision	Yes, who_____
No	Lazy eye	Yes, who_____	No	Cataracts	Yes, who_____
No	Macular degeneration	Yes, who_____	Other_____		

Please circle each. Do you or your family have any of the following conditions:

No	Diabetes	Yes, who_____
No	High blood pressure	Yes, who_____
No	Heart disease	Yes, who_____
No	Cancer	Yes, who_____
No	Respiratory (Asthma/Emphysema/Chronic Bronchitis)	Yes, who_____
No	Thyroid	Yes, who_____
No	Genitourinary (Genitals/Kidney/Bladder)	Yes, who_____
No	Liver	Yes, who_____
No	Ear/Nose/Throat (Deafness/Sinusitis/Dry Mouth)	Yes, who_____
No	Gastrointestinal	Yes, who_____
No	Constitutional (Fever/Weight Loss/Gain)	Yes, who_____
No	Integumentary/Skin	Yes, who_____
No	Neurological (Headaches/Migraines/Seizures)	Yes, who_____
No	Musculoskeletal (Rheumatoid Arthritis/Muscle/Joint Pain)	Yes, who_____
No	Lymphatic/Hematologic	Yes, who_____
No	Allergic/Immunologic (Autoimmune Disease/HIV/AIDS)	Yes, who_____
No	Psychiatric (Depression/Anxiety)	Yes, who_____

Other_____

Please list current medications: _____

Please list any allergies to medication: _____

DILATED FUNDUS EXAM:
EXPLANATION AND AUTHORIZATION

Dilation of the pupils of your eyes is an important component of every comprehensive eye exam. It allows your doctor to examine the inside of your eye and to obtain better views of the blood vessels, nerves and peripheral retina (back surface of eye). Many eye diseases and conditions can be detected with a dilated exam, including glaucoma, macular degeneration, cataracts, and retinal tears or detachments. Additionally, systemic conditions such as high blood pressure, diabetes, HIV, Lupus, cancer, multiple sclerosis, and sickle cell disease can cause changes or damage in the back of the eye. In some cases, these diseases can be detected before the patient is aware of the condition. Any of these conditions can cause significant and/or permanent vision loss.

We recommend a dilated retinal exam for every new patient as part of a comprehensive vision exam. During the examination, drops will be placed in the eyes. Dilation of the pupils will begin in 10-15 minutes. Patients will experience hazy vision and increased sensitivity to light. These effects will last for several hours, after which the pupils return to normal size. Temporary sunglasses will be provided for you, if necessary. Precautions should be taken with stairs and driving. By choosing <u>not</u> to have this exam, sight threatening diseases and conditions can go undetected.

_____ Yes, I wish to be dilated.

_____ No, I do not want to be dilated.

_____ I would like to RESCHEDULE the dilated exam.

ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the HIPAA Notice of Privacy Practices.

_____ Signature of patient or guardian

_____ Date