Patient Information & Medical History Form

Name____ Date__________________

Address________________________________ Birth Date_____________ Age _______

City________________________________ State__________ Zip Code_____________

Employer__________________________________ Occupation ______________________________

Phone_( )______________________ Email_______________________________________

How did you hear/find out about us? Referral___ Newspaper___ Sign___ Internet___ Patient___

Other: _____________________________________

Are you interested in new **Eyeglasses** / **Contact Lenses** / **Both**? (Circle)

Do you currently wear contacts? **Yes** / **No** Which type? _____________________________________

What is the reason for your visit today? ____

Primary Medical Doctor ____

Current Medications ____

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Do you have any allergies to any medications? ____

Are you pregnant or breastfeeding? **Yes** / **No**

EYE INFORMATION (Check all that apply)

Cataracts	Self ☐	Family ☐	**Crossed Eyes**	Self ☐	Family ☐	**Glaucoma**	Self ☐	Family ☐
Keratoconus	Self ☐	Family ☐	**Macular**	Self ☐	Family ☐	**Blindness**	Self ☐	Family ☐
Eye Surgery	Self ☐	Family ☐	**Degeneration**	Self ☐	Family ☐	**Retinal Disease**	Self ☐	Family ☐
Amblyopia (Lazy Eye)	Self ☐	Family ☐			☐			

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? (Check all that apply)

Dry Eyes	☐	**Blurry Vision**	☐	**Double Vision**	☐
Flashes of Light	☐	**Floaters**	☐	**Itchy Eyes**	☐
Redness	☐	**Watery Eyes**	☐	**Light Sensitivity**	☐

REVIEW OF SYSTEMS (Check all that apply)

Heart Problems	Self ☐	Family ☐	**Cancer**	Self ☐	Family ☐
Vascular Disease	Self ☐	Family ☐	**Thyroid Disorder**	Self ☐	Family ☐
Seasonal Allergies	Self ☐	Family ☐	**Uirinary Disorder**	Self ☐	Family ☐
Rheumatoid Arthritis	Self ☐	Family ☐	**Blood Disorder**	Self ☐	Family ☐
High Blood Pressure	Self ☐	Family ☐	**Respiratory Disorder**	Self ☐	Family ☐
High Cholesteral	Self ☐	Family ☐	**Multiple Sclerosis**	Self ☐	Family ☐
Diabetes	Self ☐	Family ☐	**Psychiatric Disorder**	Self ☐	Family ☐
GI (Stomach) Disorder	Self ☐	Family ☐	**Other Major Illness**	Self ☐	Family ☐

If you answered YES to any of the above or have a condition not listed, please explain

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Doctor's Signature____ Date____________________

Dilated Exam Information

It is recommended to have a dilated eye exam as part of a thorough routine health assessment. Dilating the pupils allows for a more unrestricted view of the interior of the eye. Diseases of the eye such as glaucoma, cataracts, macular degeneration and other ocular diseases can go undetected without regular dilation. Additionally, medical conditions such as diabetes, high blood pressure, high cholesterol, and many others can produce harmful changes to the eye. **This test can help assure early detection and limit vision loss! The charge for this eye health procedure is an additional $20.00.** Some vision insurance plans will cover this fee.

Side effects of the dilation drops may include blurred near vision and light sensitivity for 2-4 hours. Sunglasses can be provided to limit sun exposure.

Please check one:

- ☐ **Yes, I would like my eyes dilated**
- ☐ **I would like to schedule the dilation for a later date**
- ☐ **No, I do not wish to be dilated**

Visual Field Examination

A new computerized instrument now allows us to provide a more thorough analysis of your eyes. This new instrument is the Visual Field Analyzer which electronically measures peripheral retinal function. It does not require any eye drops, and is a straightforward, painless test.

This measurement can assist the doctor in the early detection of many visual and neurological disorders including: *Glaucoma, Brain tumors, Diabetic Retinopathy, Retinal Detachments, Hypertensive Retinopathy, and many other conditions* which can manifest in the eye.

We Strongly recommend that all patients receive the screening version of this exam, but it is especially important for patients who have: *headaches, see flashes of light or floaters, have a history of diabetes, high blood pressure, heat or circulatory problems, patients taking certain medications, a strong eyeglass prescription, or reduced vision without apparent reason*.

There is an additional charge of $10.00 for this screening exam.

Please check one:

- ☐ **Yes, I would like to have the Visual Field Exam**
- ☐ **No, I do not want to have the Visual Field Exam**

ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

As part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examinations, and test results, diagnosis, treatments and any plans for future care or treatment. By signing this form, you acknowledge receipt of Affordable Eyecare's Notice of Privacy Practices. If you would like a copy of the entire Privacy Act, the staff will provide one for you.

I acknowledge that I have been provided with and understand Affordable Eyecare's Privacy Practice

Patient Name ____

Signature ____ **Date** ________________