Patient Information and 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___ Friend___ 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 _____
Do you have any allergies to medications? _____
Are you pregnant or breast feeding? Yes / No

Eye Information (Check all that apply)

Cataracts	( ) Self ( ) Family	Crossed Eyes	( ) Self ( ) Family	Glaucoma	( ) Self ( ) Family
Keratoconus	( ) Self ( ) Family	Macular Deg	( ) Self ( ) Family	Blindness	( ) Self ( ) Family
Eye Surgery	( ) 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 Symptoms (Check all that apply)

Heart Problems	( ) Self ( ) Family	Cancer	( ) Self ( ) Family
Vascular Disease	( ) Self ( ) Family	Thyroid Disorder	( ) Self ( ) Family
Seasonal Allergies	( ) Self ( ) Family	Urinary Disorder	( ) Self ( ) Family
Rheumatoid Arthritis	( ) Self ( ) Family	Blood Disorder	( ) Self ( ) Family
High Blood Pressure	( ) Self ( ) Family	Respiratory Disorder	( ) Self ( ) Family
High Cholesterol	( ) 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:

_____

_____

_____

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 $30.00. 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 $20.00 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 RECEIPT OF NOTICE OF PRIVACY STANDARDS

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_____