

PERSONAL AND MEDICAL BACKGROUND INFORMATION

Patient Name _____ Date _____ Time _____

E-Mail _____

1. The main reason/s for today's visit is / are: _____

2. When was your last: Eye Examination? _____ General Physical? _____ Your Physician? _____

3. **MEDICAL HISTORY: LIST ALL medical problems** (Diabetes, High Blood Pressure, Kidney Disease, Cancer, etc.) and **ALL medications** that you are taking, and **what you are taking them for:** (if more than 2, please ask us for additional sheet)

4. **EYE AND HEAD HISTORY:**
Have you ever had any serious injuries, illnesses, or surgeries to your eyes or head? **Yes No**
If "YES", please describe

5. Headaches? If "YES" please describe what part of the head and how often: **Yes No**
6. _____

6. **FAMILY MEDICAL AND EYE HISTORY:**
Is there any history of severe eye problems or health problems in your immediate family?..... **Yes No**
If "YES", please describe:

7. Medical Insurance: _____ Has this changed? **Yes No**
8. Vision Plan: _____ Has this changed? **Yes No**

9. **OPTOMAP RETINAL EXAM:**
The Optomap Retinal Examination is a picture of the retina (back part of the eye), without the need for eye drops. The advantages to you are that:
1. You are able to see the back part of your own eye, and have the doctor explain the findings.
2. Fast (less than 1 second per eye) and there is No blurred vision afterwards.
3. This now is part of your record, and allows us to compare the retina from year to year.

This new technology is great, and I want to have this test..... **Yes No**
I understand that the cost of this test is an additional \$35.00

10. Name of: Husband _____ Wife _____
If patient is a child: Father _____ Mother _____
Please list your children's names and their ages: _____

11. If you are wearing **Contact Lenses**, this obligates us to assess the fit, positioning, power, corneal health, etc. with the contact lenses on, and then assess your cornea and prescription (refraction) after removing your contact lenses. This additional testing is the **Contact Lens Assessment** and is separate from a Comprehensive Examination. The fee for this assessment starts at: \$25.00.

12. The Comprehensive Examination addresses eye health and eyeglass prescriptions. **The fee for additional testing**, such as Dilation, Contact Lens Assessment, Contact Lens Examination, Orthokeratology, Sensory Motor Evaluation, LASIK Evaluation, etc., **is separate from the comprehensive examination.**

Please initial here _____

PLEASE TURN OVER – Continued on other side

1. Do you see clearly at distance, for example, driving or watching TV, with:
 Eyeglasses **Contact Lenses** or **Without eyeglasses or contact lenses**
2. Do you see clearly when doing near tasks, for example reading, sewing, computer, with:
 Eyeglasses **Contact Lenses** or **Without eyeglasses or contact lenses**
3. Do you drive?..... **Yes No**
4. Do you currently wear: Eyeglasses?..... **Yes No**
Contact Lenses?..... **Yes No**
5. Have you worn Eyeglasses, but stopped wearing them?..... **Yes No**
6. Have you worn Contact Lenses, but stopped wearing them?..... **Yes No**
7. Are you planning to get new eyeglasses today?..... **Yes No**
8. Are you planning to get contact lenses?..... **Yes No**
9. If so, are you interested in changing your eye color?..... **Yes No**
10. Are you interested in finding out more about Laser Vision Correction?..... **Yes No**
11. Are you interested in learning about a Non-Surgical method to correct your vision?..... **Yes No**
12. Do your eyes ever ... Burn Itch Have discharge Feel dry tear or water excessively
13. Do your eyes feel ... Painful Achy Irritated as though there is something in your eyes
14. Do you ever see ... Double Floaters Flashes of light Sudden blurred or reduced vision
15. Are you bothered by ... Glare Smoke Sinus problems Allergies
Bright sunlight Artificial lights Car headlights

LIFESTYLE HISTORY

1. Occupation - what type of work do you do? _____
At work, do you...
 - stand a lot of work above eye level
 - sit use the computer extensively
2. How much time do you spend on computer? ____hours each day OR ____hours each week
3. Hobbies - what types of things do you like to do?
 - Walk Reading
 - Paint Musical Instruments: which? _____
 - Play Cards Crafts: which? _____
 - Crosswords Other _____
4. What sports are you involved in?
 - Jogging Football Racquetball
 - Basketball Swimming Other _____
 - Skiing Tennis
 - Aerobics Golf