Color: OD P/F OS P/F OU P/F Stereo: P/F VF: P/F BP:___/___ Pulse:____ iCare OD____ OS____

Patient Name (Mr/ Mrs/ Ms/ Dr)____
Birth date _________/ __________/ ___________ SSN _______________________________
Address ____
City _________________________________ State ________ Zipcode______________
Phone (home) _________________ (work) _________________ (mobile) ____________________
☐ Okay to leave voice message ☐ Okay to text ☐ Okay to email
Email address ____

Medical Insurer ____
Pharmacy name & cross streets____
Emergency Contact & relationship______________________________ Contact Number _____________

Occupation & Employer ____
How did you hear about us ____
****

Top concern that you want your doctor to address at today's visit:
____

A dilated exam *is necessary to view the peripheral retina and is included in your comprehensive exam today at no additional charge. Dilation causes light sensitivity and blur for near work lasting up to 10 hours. It adds an additional 30 minutes to exam time. It can interfere with driving, work and school schedules.* *We offer an alternative at a nominal fee, which is not covered by your insurance.* *Instead of dilation today, we can do ultra-wide field photography that gives us a much fuller view (up to 200 degrees) than our standard retinal photos (30 degrees) that are included with your exam today. This allows our doctors to ensure that you are not at risk for diabetes, retinal detachments, retinal cancers and other peripheral diseases. We will take images that can be reviewed with the Doctor today and stored in our database for future reference for an out of pocket fee of $30.*

☐I have read the above ☐I can be dilated today ☐I request ultra-wide field photography

Do you currently wear glasses? ☐No ☐Yes, How old are your present pairs?______________________
When do you wear your glasses?____
Do you have prescription sunglasses? ☐No ☐Yes, How old are your present pairs?________________

Do you use any eye drops? ☐No ☐Yes, type/frequency: ______________________________________

☐ I am a current contact lens wearer and I want to be evaluated for lenses today
Current lenses are comfortable? ☐Yes ☐No, explain: ________________________________
#days per week of lens wear, on average? ______ #hours per day of wear, on average? _________
#nights slept in lenses per week?_________ How old is current pair? _______________________
How often do you replace your lenses? why?____
Cleaning solutions used?____
☐ I am interested in contact lenses for the first time

CONTACT LENS WEARERS*: I understand that contact lenses are a medical device regulated by the FDA. Contacts have a limited and controlled life-span. Like any medical device, proper care is necessary. I understand the necessity of follow-up care to monitor my health. I understand that the use of this medical device presents risk of possible infection and other complications. I understand that contact lenses do not take the place of glasses; they are an adjunct to glasses.*

☐I have read the above and I accept the responsibility for wearing contact lenses

By signing below, I agree that the above information is true/ accurate and constitutes a "signature on file" for your insurance company. I also certify that I have been notified about dilation and accept the consequences of refusal. I have been informed of Privacy Policies for protected health information. Office policy is payment at the time of service. We can provide you with forms for you to submit claims to your insurance company.

Signature ____ **Date** ________________
Parent/ Guardian if patient under 18 years old

Turn over to continue to medical questionnaire ⇩

Current Medical Doctor__________________________________ **Last Medical Exam** _____________
Prior Eye Doctor____ Last Medical Exam ______________

Do you have allergies to medications? ☐No ☐Yes, explain: _____________________________________
List ALL medications you take (including contraceptives, aspirin, over-the-counter medications, supplements and home remedies):
____
____

List all your eye injuries, eye treatments and eye surgeries (including LASIK and other refractive procedures):____

Do you get chiropractic adjustments? ☐No ☐Yes Date of last neck adjustment:_____________________

Have you had Cancer? ☐No ☐Yes, type/ when: ____

Do you smoke cigarettes? ☐No, when did you quit?________ ☐Yes, #packs/week: _________________
Do you vape? ☐No ☐Yes, amount/how long: ____
Do you drink alcohol? ☐No ☐Yes, # drinks per week: ____
Do you use medical marijuana? ☐No ☐Yes, amount/frequency: ___________________________________
When did you last use marijuana in any form?____
Do you use recreational drugs? ☐No ☐Yes, type/how long: ____________________________________

Have you ever been exposed to or infected with: ☐HIV ☐Hepatitis ☐Syphilis ☐Gonorrhea ☐Zika ☐Lyme Disease ☐West Nile Virus ☐Valley Fever ☐Herpes ☐Cold Sores ☐No, I have not

Do you CURRENTLY have, or had IN PAST, or does a FAMILY member have any of the following:

	CURRENT	PAST
Blurred Vision	☐	☐
Halos/ Glare	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Redness	☐	☐
Discharge or mucus	☐	☐
Excess Tearing/ Watering	☐	☐
Sandy/ Gritty Eyes	☐	☐
Itchy Eyes	☐	☐
Burning	☐	☐
Tired Eyes	☐	☐
Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Recent onset Floaters	☐	☐
Lid Bumps	☐	☐

	CURRENT	PAST	RELATIVE
Cataracts	☐	☐	☐
Glaucoma	☐	☐	☐
Macular Disease	☐	☐	☐
Learning Disability	☐	☐	☐
Retinal Detachment	☐	☐	☐
Eye Turn/ Strabismus	☐	☐	☐
Lazy Eye/ Amblyopia	☐	☐	☐

Psychiatric diagnosis____________________________
Psychiatric treatment___________________________

	CURRENT	PAST
Migraines/ Headaches	☐	☐
Seizures	☐	☐
Allergies/Hayfever	☐	☐
Sinus Congestion	☐	☐
Dry throat/ mouth	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Chronic Bronchitis	☐	☐
Sleep Apnea	☐	☐
Heart Disease	☐	☐
Vascular Disease	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Stroke/ Brain Injury	☐	☐
GI Disease	☐	☐
Kidney/ Bladder	☐	☐
Liver Disease	☐	☐
Arthritis	☐	☐
Lupus	☐	☐
Diabetes, Insulin	☐	☐
Diabetes, Non-Insulin	☐	☐
Hyper/Hypo Thyroid	☐	☐
Autoimmune Disease	☐	☐
Anemia	☐	☐
Hormonal changes	☐	☐
Bleeding/ Clotting	☐	☐

Other Medical Concerns or Diagnosis:____

Are you pregnant? ☐No ☐Yes Nursing? ☐No ☐Yes Trying to get pregnant? ☐No ☐Yes