Color: P/F__________ Stereo: P/F__________ VF: P/F BP:____________ Pulse:______

Patient Name (Mr/ Mrs/ Ms/ Dr)____

Address ____
City ____ State ________ Zipcode______________
Phone (home) _________________ (work) _________________ (mobile) ______________________
☐ Okay to leave voice message ☐ Okay to text ☐ Okay to email
Email address ____

Birth date _________/ __________/ ___________ SSN _______________________________________
Medical Insurer ____
Occupation & Employer ____

Emergency Contact & relationship______________________________ Contact Number _____________
How did you hear about us ____

Main Reason for today's visit____

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: _______________________________________

DILATION should ALWAYS be done because it allows for a thorough evaluation of your eyes. **It is NECESSARY to detect many sight-threatening conditions**. It should be done at ALL ages. These eye drops enlarge your pupils and will increase your sensitivity to light and blur your near vision. Most patients are able to drive afterwards. The effects last up to eight hours and requires an additional 30 minutes. There is no additional fee if the dilation is done as part of your examination today.
If you opt out today and choose to return at another time, then there will be additional office visit fees for dilation and require another 50 minutes of your time to complete.

☐I have read the above ☐I can be dilated today ☐ I refuse dilation today
☐I will schedule a dilation with office visit fee at future date

☐ 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?____

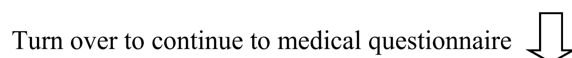
☐ I am interested in contact lenses for the first time

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

Last Eye Doctor____ Last Eye Exam _____________
Current Medical Doctor_________________________________ Last Medical Exam ___________

Do you have allergies to medications? ☐No ☐Yes, explain: ______________________________
List any medications you take (including contraceptives, aspirin, over-the-counter medications and home remedies):
____
____
List all your eye injuries, eye treatments and eye surgeries:______________________________
____

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: ___________________________
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	RELATIVE		CURRENT	PAST	RELATIVE
Loss of Vision	☐	☐	☐	Headaches	☐	☐	☐
Blurred Vision	☐	☐	☐	Migraines	☐	☐	☐
Halos	☐	☐	☐	Seizures	☐	☐	☐
Double Vision	☐	☐	☐	Allergies/Hayfever	☐	☐	☐
Dryness	☐	☐	☐	Sinus Congestion	☐	☐	☐
Redness	☐	☐	☐	Dry throat/ mouth	☐	☐	☐
Discharge or mucus	☐	☐	☐	Asthma	☐	☐	☐
Excess Tearing/ Watering	☐	☐	☐	Emphysema	☐	☐	☐
Sandy/ Gritty Eyes	☐	☐	☐	Chronic Bronchitis	☐	☐	☐
Itchy Eyes	☐	☐	☐	Sleep Apnea	☐	☐	☐
Burning	☐	☐	☐	Heart Disease	☐	☐	☐
Foreign Body Sensation	☐	☐	☐	Vascular Disease	☐	☐	☐
Glare/ Light Sensitivity	☐	☐	☐	High Blood Pressure	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐	High Cholesterol	☐	☐	☐
Lid Irritation	☐	☐	☐	Stroke/ Brain Injury	☐	☐	☐
Lid Bumps	☐	☐	☐	GI Disease	☐	☐	☐
Floaters in Vision	☐	☐	☐	Kidney/ Bladder	☐	☐	☐
Flashes in Vision	☐	☐	☐	Liver Disease	☐	☐	☐
Tired Eyes	☐	☐	☐	Arthritis	☐	☐	☐
Cataracts	☐	☐	☐	Muscle/ Joint Pain	☐	☐	☐
Macular Disease	☐	☐	☐	Diabetes, Insulin	☐	☐	☐
Glaucoma	☐	☐	☐	Diabetes, Non-Insulin	☐	☐	☐
Retinal Detachment	☐	☐	☐	Lupus	☐	☐	☐
Eye Turn/ Strabismus	☐	☐	☐	Thyroid Disease	☐	☐	☐
Lazy Eye/ Amblyopia	☐	☐	☐	Autoimmune Disease	☐	☐	☐
Eye Injury	☐	☐	☐	Hyper/Hypo Thyroid	☐	☐	☐
Learning Disability	☐	☐	☐	Anemia	☐	☐	☐
Hormonal changes	☐	☐	☐	Bleeding/ Clotting	☐	☐	☐

Psychiatric diagnosis________________________ Psychiatric treatment____________________

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