

**JOLLY GOOD EYE CARE  
PATIENT REGISTRATION AND HEALTH INFORMATION**

Patient's Name \_\_\_\_\_ Sex      M      F Date: \_\_\_\_\_  
 Parent/ Guardian \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 \_\_\_\_\_ Occupation \_\_\_\_\_  
 Home/Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Vision/Medical Insurance \_\_\_\_\_ Email \_\_\_\_\_  
 If you were referred by someone, whom may we thank? \_\_\_\_\_  
 Last Eye Exam: \_\_\_\_\_  
 Do you wear      Glasses      Contacts      Both      None

**Patients Visual Symptoms: (please check all appropriate items)**

Blurred Distance       Glare       Contact Lens Problem       Double vision  
 Blurred Near       See flashes       Replace current contacts       Headaches  
 Itchy watery eyes       See floaters/ spots       Eye infection/ trauma       No complaint  
 Eyestrain/ tired       Red eyes       Eyes burn

**Please answer the following questions about your medical status and history:**

1. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, thyroid, arthritis, etc)?  
     no      yes: please explain: \_\_\_\_\_  
 2. Have you ever had any eye disease (e.g. glaucoma, cataract, lazy eye, retinal detachment, etc)?  
     no      yes: please explain: \_\_\_\_\_  
 3. Have you ever had any surgery? (e.g. LASIK, back, etc)?  
     no      yes: please explain \_\_\_\_\_

**Review of Systems:**

Do you currently experience: If YES, please explain

Chronic Fever, weight loss/gain, fatigue	⇒	<u>    </u> no <u>    </u> yes: _____
ENT problem (Allergies, hearing problem)	⇒	<u>    </u> no <u>    </u> yes: _____
Heart Problem(High BP, Heart Dz,)	⇒	<u>    </u> no <u>    </u> yes: _____
Resp problem:(Asthma, bronchitis)	⇒	<u>    </u> no <u>    </u> yes: _____
GI problem:(Diarrhea, vomit,heartburn)	⇒	<u>    </u> no <u>    </u> yes: _____
Urinary problem:(pain, blood in urine)	⇒	<u>    </u> no <u>    </u> yes: _____
Muscoskeletal problem:(muscle ache, joints)	⇒	<u>    </u> no <u>    </u> yes: _____
Skin problem:(rash, excess dryness)	⇒	<u>    </u> no <u>    </u> yes: _____
Neuro problem: (headaches, numb)	⇒	<u>    </u> no <u>    </u> yes: _____
Psyc problem:(depression, anxiety)	⇒	<u>    </u> no <u>    </u> yes: _____
Immune problem (Rheumatoid, HIV/AIDS)	⇒	<u>    </u> no <u>    </u> yes: _____
Endocrine problem: (Diabetes, thyroid)	⇒	<u>    </u> no <u>    </u> yes: _____

**Family History:**

Please list any medical conditions or eye conditions that run in the family (such as listed above):

\_\_\_\_\_

\_\_\_\_\_

List any medications, hormones, oral contraceptives, vitamins you are presently taking and state for what condition

\_\_\_\_\_

\_\_\_\_\_

List any medications to which you are allergic: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/ Guardian Signature (if patient is a minor) \_\_\_\_\_

Here, at Jolly Good Eye Care, we strive to provide not only professional quality glasses and contact lens exams, but also the highest quality eye health assessments. You have a choice in how we approach the health part of the exam:

**Assessing the Retina:**

One of the most important, but more difficult, parts of the eye to assess is the posterior of the eye, or the retina. By carefully viewing your retina, your eye doctor can find certain pathologies like retinal holes, glaucoma, macular degeneration, diabetes, hypertension and other illnesses. Early detection of eye diseases is important in providing the best eye care. We now offer you 2 choices for how to assess the health of your retina:

**Optomap Retinal Imaging**

The Optomap is a state of the art camera that allows us to photograph a large section of your retina **without having to use any eye drops**. It is **non invasive**. You and your doctor can view the inside of your eye together, and your doctor has a permanent record of the status of your retina for years to come. The Optomap is not typically covered by vision insurances, and sometimes covered by medical insurance. The out of pocket expense is \$35.

**Dilation**

The traditional option for viewing your retina is dilation of the eye. This is the procedure where your doctor puts drops in your eyes to open your pupil to see large sections of your retina in detail. However, it has **2 side effects that typically last 4-8 hours: you will be sensitive to lights, and your near vision will be significantly impaired**. The out of pocket expense is \$25.

Which would you prefer today (circle one)? **Optomap or Dilation or None**

**Assessing Peripheral Vision:**

The computerized instrument now enables us to provide a more thorough visual field screening analysis. This instrument checks for areas of loss of sight both in the central (straight ahead) and peripheral (side view) areas. Visual field testing assists us in early detection of glaucoma, retinal problems, and some neurological diseases (such as brain tumors and optic nerve diseases.) Unfortunately, most visual field defects are not noticed by an individual until very late stages. Early detection significantly increases the chance of treating the disorder or at least minimizing its effects.

Would you like us to perform a **Visual Field Screening** (additional \$20)? **Yes or No**

**If you choose not to have one or more of the above tests performed, please sign the liability release below:**

**Liability Release:** I have been informed by Jolly Good Eye Care of the importance of a visual field screening, retinal imaging/ dilated fundus exam. I have chosen not to have one or both of these tests performed. I will not hold Jolly Good Eye Care responsible for any disease or pathology that goes undetected due to the lack of diagnostic information that could have been obtained by these testing procedures.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_