First Name	Last Name	□ Male □ Female	Birthdate	Age	Occupation
Address	City	State	Zip		Last 4 SS
Email	Phone number □Home □ Cell □Work				Preferred method of contact □ Text □ Call □ Email

Vision Insurance of Primary
(Last)____________________(First)____________________
Street ______________________ City _______________ State_____
Zip_____________ □ SAME address as listed above
DOB: ___________________ Age______ Gender □ Male □ Female
Phone Number _______________ Insured Employer_____________

Which vision insurance do you carry? □ No Vision Insurance
□ VSP
□ Davis Vision
□ Cigna
□ NVA
□ Other:_________________________
□Superior Vision
□ Spectera

What is the main reason for your visit? ____

Check all that apply: □ Glasses exam □ Contact lens exam □ Medical eye exam

What are your vision complaints?
□ Blurry Vision at □ Distance □ Near
□ Routine Visit □ Red Eyes □ Painful Eyes
When does this occur? □ Constant
□ Sometimes □ Comes and goes
Which Eye? □ Right □ Left □ Both
How long has this occurred?___________
Do you wear glasses? □ Y □ N
If yes, do you wear them for?
□ Far □ Near □Both
Do you wear contact lenses? □ Y □ N
What brand? _________________________
How often do you replace them? ________

Date of last eye exam _________________
Date of last medical exam ______________
Do you have allergies to any medication?
□ Y □ N
If so, which? Please list all
____
____

Do you see flashes of light in your eyes?
□ Y □N
Do you see floaters in your eyes?
□ Y □ N
Do you suffer from temporary blackouts of your vision?
□ Y □ N

Do you take medications? □ Y □ N
If so, which? Please list ALL
____
____
____
____
____
____
____

Do you take **eye** medications? □ Y □ N
If so, which? Please list ALL
____
____
____

Do you have any medical conditions?
□ **NONE**
□ High blood pressure
□ Diabetes
What is your last blood sugar? _________
What is your last A1c?________________
When do you see your PCP next? _______
□ Lung Disease
□ Cancer
□ Rheumatoid Arthritis
□ Sarcoidosis
□ Seizures
□ Multiple Sclerosis
□ HIV/AIDS
□ Other
____

Have you had any surgeries in the past?
□ **NONE**
□ YES, please list
____

Do you have any previous eye conditions?
□ **NONE**
□ Dry Eyes
□ Glaucoma
□ Retinal Detachment
□ Retinal Disease
□ Strabismus (Eye turn)
□ Amblyopia (Lazy Eye)
□ Keratoconus
□ Glaucoma
□ Diabetic Retinopathy
□ Macular Degeneration
□ Iritis
□ Optic Nerve disease

Have you previously had eye surgery for?
□ **NONE**
□ Cataract
□ Retinal Detachment
□ Muscle Surgery
□ Trauma
□ LASIK/PRK
□ Foreign body removal
□ Other _____________________________

Does anyone in your family have any medical conditions?
□ **NONE**
□ High blood pressure
□ Diabetes
□ Lung Disease
□ Cancer
□ Rheumatoid Arthritis
□ Sarcoidosis
□ Seizures
□ Multiple Sclerosis
□ HIV/AIDS
□ Other
____

Has anyone in your family had visual problems or blinding conditions?
□ **NONE**
□ Glaucoma
□ Diabetes
□ Cataracts
□ Macular Degeneration
□ Keratoconus
□ Other ________________________

Do you suffer from headaches? □ Y □ N
Do you suffer w/seasonal allergies? □ Y □ N
Are you pregnant or breastfeeding? □ Y □ N

Social History
Tobacco Use □Current Smoker
□Former Smoker □ Never Smoked
Alcohol □ Yes, _____ per week □ No
Recreational Drug Use
□Yes □No □Unknown

Sexually Transmitted Disease □Yes □No
If yes, which?____________________

Review of Systems:

Are you currently experiencing problems with any of the following?

Allergy / Immunologic: □ No □ Yes, circle which (Hives, Eczema, Rash, Lumps) other_______

Cardiovascular: □ No □ Yes, circle which (Chest Pain, Palpitations, Difficuly Breathing, Endema) other_______

Constitutional: □ No □ Yes, circle which (Fever, Chills, Weight Gain, Weight Loss) other_______

Endocrine: □ No □ Yes, circle which (Heat/Cold Intolerance, Frequent Urination, Thirst, Appetite) other_____

Gastrointestinal: □ No □ Yes, circle which (Heartburn, Nausea, Constipation, Diarrhea) other_______

Genitourinary: □ No □ Yes, circle which (Burning, Pain, Nocturia, Sexual Function) other_______

Ear/Nose/Mouth/Throat: □ No □ Yes, circle which (Decreased Hearing, Discharge, Dryness, Hoarseness) other_______

Hematologic/Lymphatic: □ No □ Yes, circle which (Bruising, Bleeding, Anemia) other_______

Integumentary: □ No □ Yes, circle which (Moles, Non-healing lesions, Dryness, Color changes) other_______

Musculoskeletal: □ No □ Yes, circle which (Muscles/Joint Pain, Stiffness, Back Pain, Joint Swelling) other_______

Neurological: □ No □ Yes, circle which (Dizziness, Fainting, Seizures, Weakness) other_______

Psychiatric: □ No □ Yes, circle which (Nervousness, Depression, Memory Loss, Stress) other_______

Respiratory: □ No □ Yes, circle which (Cough, Sputum, Shortness of Breath, Wheezing) other_______

COVID-19 Questionaire

Have you traveled any high-risk COVID-19 areas in the last 2 week?

□Yes, where? _________________________________ □No

Have you been come into contact with anyone who has traveled to any high-risk areas COVID-19 in the last 2 weeks?

□Yes □No

Are you currently experiencing a cough, fever or other flu like symptoms?

□Yes □No

Have you had COVID in the past?

□Yes □No

Temperature (intake by staff) _____________Degrees F

Informed Consent for Dilated Fundus Exam

Medical research indicates that many people need their pupils dilated to rule out any eye disease that may cause the loss of their sight or worse. The dilated fundus examination is recommended for all patients who are new to the practice, have diabetes, high blood pressure, lupus, have flashes or floaters, those who have retinal problems, highly near-sighted, history of cancer, those having experienced blunt head trauma within 5 years, those with unexplained headaches, unexplained visual acuity loss or at your doctor's digression. The drops are used to dilate your pupils require about 20 minutes to take effect and will keep your pupils dilated for 2-4 hours. However, your near vision will improve in 1-2 hours. The dilation will cause your vision to be temporarily blurry and sensitive to sunlight, possibly making your day's activities somewhat difficult, even with sunglasses. Side effects from the drops rarely occur but if you should experience ANY pain IN OR AROUND your eyes, hazy vision (halos around lights), or a sick feeling, PLEASE contact the doctors in our office immediately.

The Eye Wellness exam provides the doctor with a detailed photo & an MRI-like scan of the retina without dilating the eyes. The procedure is painless and has no side effects but is not covered by insurance ($39 charge). We recommend the this test for all patients, especially patients with systemic conditions such as diabetes and high blood pressure or a family history of ocular disease such as glaucoma.

Health assessment of the back of your eyes is required as part of your comprehensive exam. If both above options are denied, you accept full risk associated with undetected diseases and their timely treatment.

Please check **ALL THAT APPLY**

_____ I **WANT** to have dilation done today (included in exam, extra 20-30 minutes to examine)

_____ I **DO** want a **wellness scan** ($39 charge)

_____ I **DO NOT** want the dilation today or the wellness scan and I understand my risks

HIPPA Notice of Privacy Practices

I acknowledge that I have received or been offered the HIPPA Notice of Privacy Practices which describes the use and disclosures of my protected health information by the practice and informs me of my rights with respect to my protected health information.

Safety, sports and children's glasses: Polycarbonate and Trivex are considered the safest lens materials for children and for people involved in sports or other activities that involve danger of impact to the eyes and face.

Acknowledgement: by signing this form, I acknowledge that I understand this safety notion and have answered all the questions to the best of my abilities.

Patient or guardian (if under 18 years old) s**ignature** ____________________________________Date______________