PATIENT MEDICAL HISTORY

What problems are you having with your EYES?		How Long? # of DAYS/MONTHS/YEARS	EYE Medications *(Over The Counter and/or Prescription)* ☐ NONE	
Blurry Vision: Far | Near | Computer	☐ YES ☐ NO			
Cloudy | Foggy Vision	☐ YES ☐ NO			
Dry Eyes	☐ YES ☐ NO			
"Tired Eyes" | "Heavy Eyes"	☐ YES ☐ NO			
Redness | Itching | Burning | Gritty	☐ YES ☐ NO			
Tearing | Discharge | Eye Crusting	☐ YES ☐ NO		**Do You Currently Wear Glasses?** YES NO	
Floaters | Flashes	☐ YES ☐ NO			
Cataracts	☐ YES ☐ NO		**Do You Wear Your Glasses For:** Distance | Near | Computer | All Distances	
Glaucoma	☐ YES ☐ NO			
Macular Degeneration	☐ YES ☐ NO		**How Old Are Your Prescription Glasses?**	
Retinal Disorder |Retinal Disease	☐ YES ☐ NO		____ Day(s) | Week(s) | Month(s) | Year(s)	
Crossed Eye | "Lazy" Eye | Eye Turning	☐ YES ☐ NO		**Do You Need A Glass Prescription?** YES NO	
PAST EYE SURGERY: ☐ **NONE**			**When Was Your Last Eye Exam?**	
Cataracts ☐ RIGHT ☐ LEFT	Retinal Detachment Repair ☐ RIGHT ☐ LEFT		____ Day(s) | Week(s) | Month(s) | Year(s)	
LASIK ☐ RIGHT ☐ LEFT	Retinal Tear Repair ☐ RIGHT ☐ LEFT			

FAMILY HISTORY of EYES:
Glaucoma | Macular Degeneration/Diseases | Retinal Diseases | "Lazy Eye" | DO NOT KNOW

MEDICAL BACKGROUND: ☐ NONE APPLIES

Endocrine:
Diabetes [ ] YES [ ] NO
Hypo/Hyper Thyroid [ ] YES [ ] NO

Genitourinary:
Kidney Problems [ ] YES [ ] NO
Bladder Problems [ ] YES [ ] NO
Prostate Problems [ ] YES [ ] NO

Gastrointestinal:
Bowel Problems [ ] YES [ ] NO
Digestive Problems [ ] YES [ ] NO
Ulcer Disease [ ] YES [ ] NO
Liver Disease [ ] YES [ ] NO
Gallbladder Disease [ ] YES [ ] NO
Pancreatic Disease [ ] YES [ ] NO

Musculoskeletal:
Arthritis [ ] YES [ ] NO
Back Problems [ ] YES [ ] NO
Neck Problems [ ] YES [ ] NO

Autoimmune Disease/Disorder:
[ ] YES [ ] NO (*Please List Below*)

_____

_____

Cardiovascular:
Hypocholesteremia [ ] YES [ ] NO
Hypertension [ ] YES [ ] NO
Heart Disease [ ] YES [ ] NO
Enlarged Heart [ ] YES [ ] NO
Irregular Heart Beats [ ] YES [ ] NO

Pulmonary:
Asthma [ ] YES [ ] NO
COPD [ ] YES [ ] NO
Emphysema [ ] YES [ ] NO
Bronchitis [ ] YES [ ] NO
Tuberculosis [ ] YES [ ] NO
Pneumonia [ ] YES [ ] NO
Sarcoidosis [ ] YES [ ] NO

Mental Status:
Depression [ ] YES [ ] NO
Anxiety [ ] YES [ ] NO
Other: _____

Cancer:
[ ] YES [ ] NO (*Please List Below*)

_____

Hematology:
Anemia [ ] YES [ ] NO
HIV+ [ ] YES [ ] NO
Hepatitis [ ] YES [ ] NO
Sickle Cell / Trait [ ] YES [ ] NO

Neurology:
Stroke [ ] YES [ ] NO
Seizures [ ] YES [ ] NO
Paralysis [ ] YES [ ] NO
Dizziness [ ] YES [ ] NO
Double Vision [ ] YES [ ] NO

Head:
Headaches [ ] YES [ ] NO
Migraines [ ] YES [ ] NO
Sinus/Allergies [ ] YES [ ] NO
Stress/ Tension [ ] YES [ ] NO
w/Eye Strain [ ] YES [ ] NO
Ear Problems [ ] YES [ ] NO

OTHER:

_____

_____

ALLERGIES TO ANY MEDICATION(S): ☐ **NO KNOWN DRUG ALLERGIES**

PATIENT MEDICAL HISTORY

FAMILY MEDICAL HISTORY: (M - Mother / F - Father / S - Siblings) ☐ DO NOT KNOW

Diabetes (M / F / S) | Heart Disease (M / F / S) | Cancer (M / F / S) | Other: _____ (M / F / S)

Please List any Surgery/Surgeries you have had in the past.

☐ NONE APPLIES

_____

_____

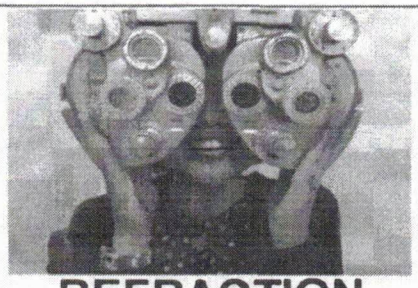
Please List ALL MEDICATIONS

☐ NONE

_____ _____ _____

_____ _____ _____

_____ _____ _____



REFRACTION

A refraction is a diagnostic procedure performed to determine the amount of corrective lens power needed to obtain your best vision. Eye doctors use this to make diagnostic decisions and recommendations during your visit when one or multiple issues may be affecting your eyes such as cataracts, glaucoma, and macular degeneration.

The fee for a refraction will be **$65.00** and is **NOT** paid by MEDICARE (or most insurance companies).

You will be asked to pay this amount today if performed.

☐ **YES**, I would like to have a refraction performed today. I also understand that my Medicare and/or Medical Insurance does not cover this procedure and I am responsible for $65.00 for it to be performed.

☐ **NO**, I decline the refraction.

☐ **UNSURE**, will follow Doctor's recommendation.

DILATION

Dilating drops are used to enlarge the pupil(s)s to allow the doctor to obtain a better view of the inside of your eye(s). Dilating drops frequently blur vision for a length of time, which varies from person to person and makes lights become bothersome. It is no possible to predict how much your vision will be affected. Because driving may be difficult immediately after examination, it is best you make arrangements not to drive yourself or wait if needed.

☐ **YES**, I have read and understand that my eye(s) will be dilated today for a thorough eye exam.

☐ **NO**, I am declining/deferring dilation today.

_____ Date: _____/_____/_____

Patient's Signature