Patient Information

□ **Check here if insurance billing address and shipping address differ**

First Name	Last Name	Name Preference	Sex assigned at birth: □ Male □ Female
Address		Date of Birth / Age	Pronouns
City	State / Zip Code	Occupation	
Mobile Number	Email Address	Primary Care Physician	

Reason for Today's Exam

□ **First Eye Exam**

□ **Routine Eye Exam** □ Glasses □ Contact Lenses

Approximate date of last exam if elsewhere _____

□ **Medical/Other**, *please explain:*

Do You Currently?

Wear Glasses? □ YES, age of current glasses: _____ □ NO

□ Distance □ Readers □ Progressives □ Bifocals

Wear Contacts? □ YES □ NO Brand _____

□ Daily Disposables

□ Monthly Disposables

□ Bimonthly Disposables

Ocular Symptoms and History

Current Ocular Symptoms: *Please check all that apply.*

□ Dry eyes
□ Itching
□ Red eyes
□ Discharge
□ Pain
□ Flashes of light
□ Floaters
□ Eyestrain
□ Headaches/migraines
□ Double vision
□ Blurred vision with glasses/contacts
□ Other *(please explain):* _____

Ocular History: *Please check all that apply.*

□ Strabismus/Lazy Eye
□ Glaucoma
□ Iritis/Uveitis
□ Macular Degeneration
□ Retinal Detachment/Disease
□ Keratoconus
□ Eye Surgeries/Injuries *(list and date):*

_____

Are you interested in refractive surgery (LASIK, PRK)? **YES / NO**

Medical History

□ I have no medical conditions to report

Please circle all that apply.

Allergies/Immune: seasonal, medical, environmental, lupus, Sjogren's syndrome

Cardiovascular: hypertension, heart disease, congestive heart failure

Ear/ Nose/Throat: hearing loss, dry mouth, vertigo, sinus

Endocrine: thyroid dysfunction, diabetes I, diabetes II

Current A1c level: _____ approx. date tested:_____

Hematologic/ Lymph: cholesterol, anemia

Integumentary: eczema, rosacea, psoriasis, shingles

Muscular/Skeleton: arthritis, fibromyalgia, muscular dystrophy

Neurological: multiple sclerosis, epilepsy, stroke, migraines

Psychiatric: depression, anxiety, ADHD

Respiratory: asthma, sleep apnea, COPD, emphysema

Pregnant or Nursing: # of weeks pregnant _____

Please list ALL medications you are taking:

Medication Allergies:

Family Ocular History: *Please circle all that apply.* glaucoma, macular degeneration, retinal disease, other:

Family Medical History: *Please circle all that apply.* diabetes, high blood pressure, cholesterol, cancer, heart disease, other:

Ocular Health Screening (Photos and OCT):

Both REQUIRED during all routine exams. Fee $55. Not covered by vision insurance.

Retinal Photos:

This test provides the doctor with a full image of the central retina and structures (optic nerve, macula, blood vessels). These images may help to detect undiagnosed eye disease. Having a baseline reference image allows your doctor to more accurately identify changes in your eye structures and treat diseases at an earlier stage.

Wellness OCT :

This is a quick, non-invasive scan that allows our doctors to see beneath the surface of your retina. This unique technology helps detect vision threatening and systemic diseases in very early stages, when they are most treatable, and impossible to detect by any other means. The images enable your doctor to see and evaluate the surface of the retina, as well as underlying tissue that cannot be viewed directly by other means during your routine examination.

I acknowledge I am fully responsible for all copayments required by my vision plan as well as any charges not covered by my vision insurance company including the $55 ocular health screening mentioned above.

Patient or Guardian Signature _____ Date _____