

PERSONAL AND MEDICAL BACKGROUND INFORMATION

This form will help us learn about you, your medical history, how you use your eyes, etc.

Patient Name _____ Date _____ Time _____

1. The main reason(s) for today's visit is:

2. When was your last eye examination? _____ Do you drive? **Yes No**

3. Do you wear or have _____ Eyeglasses **Yes No** Contact Lenses **Yes No**

4. Were eyeglasses ever prescribed for you, but you no longer wear them? **Yes No**

5. Can you see clearly at distance, for example, driving or watching TV? without eyeglasses **Yes No**
with eyeglasses **Yes No**

6. Can you see clearly up close, for example reading, sewing, computer? without eyeglasses **Yes No**
with eyeglasses **Yes No**

7. Do your eyes ever... burn itch have discharge feel dry tear or water excessively
Do your eyes feel ... painful achy irritated like there is something in your eyes
Do you ever see... double floaters flashes of light sudden blurred or reduced vision

Are you bothered by glare smoke sinus problems allergies
bright sunlight artificial lights car headlights

8. How is your general health? _____

9. When was your last general physical? _____ Who is your Physician? _____

10. **YOUR MEDICAL HISTORY:**

Please **LIST ALL** medical problems (for example: Diabetes, High Blood Pressure, Kidney Disease, Cancer, etc.) and **ALL** medications that you are taking, and what you are taking them for:

11. **YOUR EYE AND HEAD HISTORY:**

Have you ever had any serious injuries, illnesses, or surgeries to your eyes or head? **Yes No**
If "YES", please describe

12. Headaches? **Yes No** If "YES" please describe what part of the head and how often:

13. **FAMILY MEDICAL AND EYE HISTORY:**

Is there any history of severe eye problems or health problems in your immediate family? **Yes No**
If "YES", please describe:

14. Medical Insurance _____ has this changed? **Yes No**

15. Vision Plan _____ has this changed? **Yes No**

Name of _____ Husband _____ Wife _____

If patient is a child: Father _____ Mother _____

Please list your children's names and their ages _____

PLEASE TURN OVER – Continued on other side

Optomap Retinal Exam:

This new video camera takes an electronic picture of the retina (back part of the eye) without having to use eye drops. The advantages to you are that:

1. You are able to see the back part of your own eye, and have the doctor explain the findings.
2. Fast (less than 1 second per eye) and there is No blurred vision afterwards.
3. This now is part of your record, and allows us to compare the retina from year to year.

This new technology is great, and I want to have this test.

Yes No

LIFESTYLE HISTORY

Circle one

- | | | |
|---|--|--------------------------------------|
| 1. Are you planning to get new eyeglasses today? | Yes | No |
| 2. Are you planning to get contact lenses? | Yes | No |
| 2. If so, are you interested in changing your eye color? | Yes | No |
| 3. Would you be interested in <u>trying on</u> a pair of clear contact lenses, or contact lenses that changes your eye color? | Yes | No |
| 4. I understand that the fee for additional testing, such as Contact Lens Examination, Evaluation for LASIK, Orthokeratology, Sensory Motor issues, Low Vision, etc., is separate from a Comprehensive Examination, which addresses eye health and eye glass prescriptions. | Yes | No |
| 5. Are you interested in finding out more about Laser Vision Correction? | Yes | No |
| 6. Are you interested in learning about a <u>Non-Surgical</u> method to correct your vision? | Yes | No |
| 7. Are you aware of the danger of ultra-violet light on your eyes? | Yes | No |
| 8. Occupation - what type of work do you do? _____. | | |
| At work, do you... | | |
| <input type="checkbox"/> stand | <input type="checkbox"/> a lot of work above eye level | |
| <input type="checkbox"/> sit | <input type="checkbox"/> use the computer extensively | |
| 10. How much time do you spend on computer? _____hours each day OR _____hours each week | | |
| 11. Hobbies - what types of things do you like to do? | | |
| <input type="checkbox"/> Walk | <input type="checkbox"/> Reading | |
| <input type="checkbox"/> Paint | <input type="checkbox"/> Musical Instruments: which? _____ | |
| <input type="checkbox"/> Play Cards | <input type="checkbox"/> Crafts: which? _____ | |
| <input type="checkbox"/> Crossword puzzles | <input type="checkbox"/> Other _____ | |
| 12. What sports are you involved in? | | |
| <input type="checkbox"/> Jogging | <input type="checkbox"/> Football | <input type="checkbox"/> Racquetball |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Swimming | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Skiing | <input type="checkbox"/> Tennis | |
| <input type="checkbox"/> Aerobics | <input type="checkbox"/> Golf | |

If you currently wear contact lenses, please read this:

Contact Lens Assessment for patients that currently wear contact lenses:

Patients that wear contact lenses may have complications due to those lenses. When seeing patients that wear contact lenses, it is essential to assess the fit, positioning, power, health, etc. with the contact lenses on, and then examine the eyes with the contact lenses off. This additional testing is the Contact Lens Assessment is separate from a Comprehensive Examination.