PERSONAL AND MEDICAL BACKGROUND INFORMATION

Patient Name _____ Date_____ Time _____
Occupation _____ Hobbies _____ Height_____ Weight_____
Name of: Husband_____ Wife_____
If patient is a child: Father_____Mother_____
Please list the names and ages of other children (under 18) _____

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

2. When was your last Eye Examination? _____ Last General Physical? _____
3. MEDICAL HISTORY: Please list ALL …
   a. Medical Problems (Diabetes, High Blood Pressure, Kidney Disease, Cancer, etc.)
   b. Medications that you are taking, and what you are taking them for:

_____
_____
_____

4. **The Optomap Retinal Examination** is prescribed in our office to evaluate the health of your retina (back part of the eye). The advantages to you are:
   1. Fast (less than 1 second per eye)
   2. No blurred vision afterwards and no need for Dilation in most cases.
   3. You will be able to see the back part of your own eye, and the doctor will explain the findings.
   4. This is now part of your permanent record, so we can then compare the retina from year to year.

This new technology is a part of our standard of care. The fee for this test is **$45.00**.
Y N This test is ***not covered by any*** medical insurance. I choose to have this test

5. The **Comprehensive Examination** addresses eye health and eyeglass prescriptions.
6. **Contact Lens Examination:** There are 3 levels; standard, complex, and custom.
   The fee for this service is separate from the comprehensive examination.
7. A Vision Plan examination is a routine examination for healthy eyes. Medical Insurance is for MEDICAL issues such as Diabetes, Brain Injury, Strabismus (an eye turn), Amblyopia (lazy eye).

Y N EYE or HEAD injuries, illnesses, or surgeries?
Y N Headaches?
Y N Is there a family history of any severe eye problems or health problems? Explain _____
Y N Do you currently wear [ ] Eyeglasses? [ ] Contact Lenses

Are you interested in
Y N Getting Eyeglasses today?
Y N Getting Contact Lenses for full time, part time, or for occasional wear, such as sports or social events?
Y N Learning about a Non-Surgical method to correct your vision?
Y N Learning about ways to control and prevent your child from becoming more nearsighted each year?

Y N Is your child having school-related problems or difficulty reading?
Y N Are you having vision problems after LASIK or PRK?
Y N Are you having vision problems after a Brain Injury? Stroke, Crash, Fall, etc.