# PACIFIC VISION EYECARE

## Welcome To Our Office

**First Name** | | | | | | | | | | | | | | | | **Middle Initial** |

**Last Name** | | | | | | | | | | | | | | | | | | | | | |

**Preferred Name (Same) or** _____ **Age** _____ **Date of Birth** _____ **Sex** ____

**Address** _____ **City** _____ **State** _____ **Zip** _____

**Home #** _____ **Cell #** _____ **Work #** _____

**Email (optional)** _____

**Occupation / Hobbies** _____

## VISION HISTORY

**When was your last eye exam?** _____ **(can be an estimate)**

**Do you currently wear Glasses, Soft Contact Lenses or Rigid Contacts? (Please circle)**

**Was your last prescription for Glasses / Contacts filled through Costco Optical? Yes / No**

## MEDICAL HISTORY

**( please check all that apply )**

| | Patient | Family | | Patient | Family | | Patient | Family |
|---|---|---|---|---|---|---|---|---|
| **Glaucoma** | ☐ | ☐ | **Dry Eye** | ☐ | ☐ | **Diabetes** | ☐ | ☐ |
| **Macular Degeneration** | ☐ | ☐ | **Cataract Surgery** | ☐ | ☐ | **High Blood Pressure** | ☐ | ☐ |
| **Retinal Detachment** | ☐ | ☐ | **Other Eye Surgery** | ☐ | ☐ | **Cancer** | ☐ | ☐ |

**Please list any other significant medical or eye related conditions / and medications you are taking**

_____

**Please list any medications you may be allergic to:** _____

## EYE HEALTH CHECK

We offer **OPTOMAP Imaging** as a part of your comprehensive eye exam.

- OPTOMAP Imaging included in the price of standard exam.
- **No additional fee.**
- This test provides digital images with **no eye drops involved.**
- The **Doctor will review** the images with you.

In addition to **OPTOMAP**, would you also like to have your eyes **Dilated** today?

- Dilation utilizes **eye drops** that are placed in your eyes to widen the pupils.
- **Longer eye exam** (Additional 30 minutes)
- **Side effects typically last 4-6 hours** and include: ***light sensitivity*** *and* ***blurry vision*** .

☐ Please check box if **Dilation** is desired as part of today's exam.

**Federal Law requires that you be made aware of your privacy rights regarding your personal medical information. By signing below, you acknowledge that you can at any time request a copy of our HIPAA Privacy Policies. (For Patients under 18, parent or legal guardian please sign)**

**Signature:** _____ **Date:** _____