

Patient Information - Please Print and fill out completely in ink.

Insurance (vision/medical) _____ SS# _____

Last Name _____ First Name _____ MI _____

Birth date _____ Age _____ If under 18, Parents Name _____

Address _____ City _____ State _____ Zip _____

Home Ph # _____ Other Ph # _____ Occupation _____

Email address _____

Emergency Contact _____ Phone # _____

Medical History - Please indicate if *you* have had or currently have any condition(s) listed below:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Red Eye | <input type="checkbox"/> Floaters | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Retinal Disease |
| <input type="checkbox"/> Itchy Eye | <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Eye Injury | <input type="checkbox"/> Lazy/ Turned Eye | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Other |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Arthritis | |

Is there a family history of: Diabetes High blood pressure Glaucoma Retinal Disease

Reason for today's visit: Routine exam Contact Lenses Vision Problem Other _____

Any known allergies to medications: _____

List of medications (include non-prescription): _____

Do you play sports? Y/N Which ones? _____

Have you ever worn contact lenses? _____ When? _____ Brand of Contacts _____

Are you interested in LASIK eye surgery? _____

Dilation (enlargement) of the pupils allows for a more thorough assessment of the eye's internal health. It is regularly recommended as part of a complete eye examination, without which, certain diseases may not be discovered. The side effects generally last 4-6 hours. You still have the ability to operate a motor vehicle, with the use of sunglasses.

Do you wish to have your eyes dilated today? Yes No Reschedule

I authorize the vision care staff to perform the necessary health care services I (or my child) may need. I hereby agree that I am solely responsible for paying for all products ordered and services rendered (initial here _____).

As required by federal law, a copy of the office's Notice of Privacy Practices has been provided to me. I understand that it is my right to have a take-home copy upon request, or for recycling purposes I can utilize the laminated in-office copy provided (initial here _____).

Today's Date

Patient (or Guardian) Signature

Print Name of Signer

Name: _____ Age: _____ Date: _____

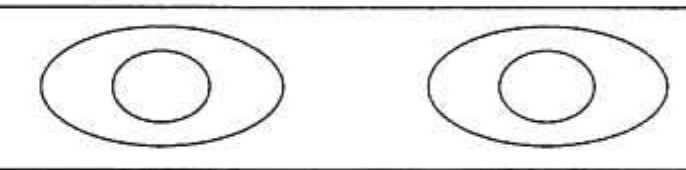
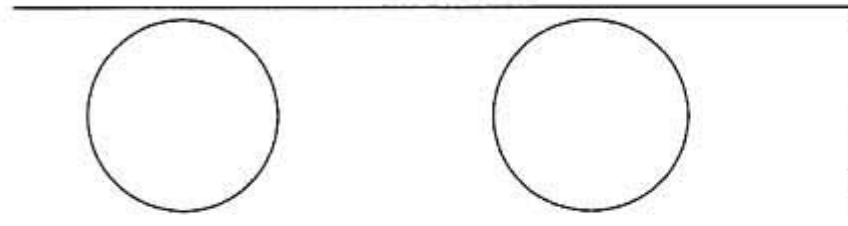
Chief Complaint _____

Current
 SRx OD _____ 20/
 OS _____ 20/
 single vision bifocal progressive
 CI Rx OD _____
 OS _____

Unaided Acuity	DVA	NVA	Stereo _____ sec
	20/	20/	Color (ISHI)
	20/	20/	_____

NCT OD _____ OS _____ Time _____ AM/PM
 Visual Fields: Auto OD Normal See
 OS Normal Printout
 Pupils: ERRLA APD: + -
 EOMS: Full Smooth
 Cover Test (Dist) _____
 (Near) _____

Refraction: OD 20/ 20/
 OS 20/ 20/
 ADD _____



Disc Mar Normal Disc: Type/Shape _____
 Disc Color C/D ratio _____
 Mac/Fovea Cup Depth _____
 Vessels A/V Ratio _____
 DFE: Tropicamide (1%/.5%) OU Other _____
 Phenylephrine (2.5%) OU @ _____ AM/PM

	Normal	Normal
Lids	<input type="checkbox"/> <input type="checkbox"/>	A/C <input type="checkbox"/> <input type="checkbox"/>
Conj	<input type="checkbox"/> <input type="checkbox"/>	Iris <input type="checkbox"/> <input type="checkbox"/>
Cornea	<input type="checkbox"/> <input type="checkbox"/>	Tears <input type="checkbox"/> <input type="checkbox"/>
Lens	<input type="checkbox"/> <input type="checkbox"/>	Angles _____

OU	Medical Diagnosis	OD	OS	OU	Refractive Diagnosis	OD	OS
<input type="checkbox"/>	Ping, PTG, Arcus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No refractive error	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Myopia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperopia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Diabetic Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Astigmatism	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Dry Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Presbyopia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anisometropia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aphakia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Ocular Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pseudophakia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Visual Field Defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Hypertensive Ret	<input type="checkbox"/>	<input type="checkbox"/>				

Refraction

No Rx Needed
 Rx change optional
 New Rx Necessary
 Final Prescription
 Refraction Above
 Rx OD
 OS

MD Referral
 Return Visit 1 year 2 year Other _____ Doctor _____