Eye History

When was your last eye examination? _____ Doctor's Name_____

Please check any of the following conditions that apply:

Condition	You	Your Family	Condition	You	Your Family
Eye surgery	☐		Eye turn/crossed eye	☐	☐
Eye injury	☐		Glaucoma	☐	☐
Vision therapy	☐		Cataract	☐	☐
Eye disease	☐	☐	Macular degeneration	☐	☐
Blindness	☐	☐	Retinal disorders	☐	☐
Lazy eye	☐	☐			

Please check any of the following conditions that apply to you:

Frequent headaches	☐			Double vision (ever)	☐
Floaters or spots	☐			Eye strain	☐
Poor distance vision:	☐			Eyes itch, burn	☐
With glasses	☐	without glasses	☐	Eyes Water	☐
Poor near vision:				Recent eye infection	☐
With glasses	☐	without glasses	☐	Sensitive to light	☐

Medical History

Please check any of the following conditions that apply:

Condition	You	Your Family	Condition	You
Diabetes	☐	☐	Sinus Problems	☐
High Blood Pressure	☐	☐	Migraine Headaches	☐
Thyroid Disease	☐	☐	AIDS/HIV	☐
Arthritis	☐	☐	Tuberculosis	☐
Heart Disease	☐	☐	STD	☐
Neurological Disorders	☐	☐	Stroke	☐
Lupus/Autoimmune Disease	☐	☐	Head Injuries/Trauma	☐
Cancer	☐	☐	Seizures	☐
Kidney Disease	☐	☐	Asthma	☐
Multiple Sclerosis	☐	☐	Pregnant	☐

Other conditions you are being treated or tested for _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s)?_____

List all Medications you are taking Reason

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

List any Medication Allergies_____

Pupil Dilation

Dilating drops are used to temporarily enlarge your pupils. This allows the doctor a more thorough examination of your retina (back of the eye) to look for eye disease that cannot otherwise be detected. Generally the effects last about 4 hours. During this time your eyes will be extra sensitive to light and your near vision may be blurred. Distance vision will be fine in most cases.

We strongly recommend that all of our patients receive this procedure. The fee for the dilated examination is $20.00. Your insurance may cover this expense.

_____ **I DO want the dilated examination.**

_____ **I DO NOT want the dilated examination.**

PATIENT'S SIGNATURE:_____ DATE: _____