PATIENT HISTORY QUESTIONNAIRE and DILATION INFORMED CONSENT

(MUST BE UPDATED AT EACH VISIT)

Name:_____ Date: _____

What brings you to our office today?_____

EYE INFORMATION

Briefly state the main kind of eye problem you are having._____
How long have you had this problem? _____

Do you currently have any of the following symptoms or problems?

Blur, strain, uncomfortable at far? ☐ Yes ☐ No Floaters? ☐ Yes ☐ No
Blur, strain, uncomfortable at near? ☐ Yes ☐ No Flashes of lights? ☐ Yes ☐ No
Eyes that are dry, itch, burn or tear ☐ Yes ☐ No Glow or halo around lights? ☐ Yes ☐ No
Light or sunlight sensitive? ☐ Yes ☐ No
Headaches? ☐ Yes ☐ No (when? where on head?)_____
Diabetes? ☐ Yes ☐ No Type: _____ Date of diagnosis:_____
Other health problems affecting your eyes? _____

Do you currently have or have you had any of the following eye problems?

Please explain (when? how long? treatment?)

Cataract ☐ Yes ☐ No _____
Glaucoma ☐ Yes ☐ No _____
Macular degeneration ☐ Yes ☐ No _____
Retinal tear or detachment ☐ Yes ☐ No _____
Blindness ☐ Yes ☐ No _____
Crossed or lazy eyes ☐ Yes ☐ No _____
Double vision ☐ Yes ☐ No _____

Have you ever had any…

Eye injury ☐ Yes ☐ No (If yes, which eye, when, what) _____
Eye operation ☐ Yes ☐ No (If yes, which eye, when, what) _____
Eye infection ☐ Yes ☐ No (If yes, which eye, when, what) _____

Do you wear Glasses? ☐ Yes ☐ No If yes, what for? _____
Have you ever worn contacts before? ☐ Yes ☐ No If yes, how long? _____ What type? _____
Do you currently wear contact lenses? ☐ Yes ☐ No How old are your lenses?_____
Are you interested in wearing contact lenses? ☐ Yes ☐ No
Are you interested in laser surgery to correct your vision? ☐ Yes ☐ No
Have you ever received vision training or eye exercises? ☐ Yes ☐ No
What is the name of your previous eye doctor: _____
When was your last eye exam?_____

LIFESTYLE

Do you work? ☐ Yes ☐ No If yes: ☐ at home? ☐ outdoors? ☐ in an office environment? ☐ mainly at night?
What is your current occupation? _____
Does your work cause undo stress on your eyes? ☐ Yes ☐ No

Do you work at or use a computer?
☐ Yes, how many hours each day? _____ ☐ No

Do you drive?
☐ Yes ☐ No If yes, are you bothered by glare when driving at night? ☐ Yes ☐ No

Hobbies *(please check all that apply)*

☐ Reading ☐ Bingo/Cards, etc. ☐ Music/Piano, etc. ☐ Skiing
☐ Sewing ☐ Gardening ☐ Racquetball/Tennis ☐ Woodworking/Shop
☐ Fishing ☐ Bowling ☐ Golf ☐ Other_____

What other recreational activities do you enjoy?_____

Please turn over and complete other side

MEDICAL INFORMATION

Do you now have or have you had any problems with any of these body systems? ***(please check one box for each category)***

	Yes	No	?		Yes	No	?
Gastrointestinal (stomach/intestine)	☐	☐	☐	Musculoskeletal (bones, joints, muscles)	☐	☐	☐
Ears/Nose/Throat	☐	☐	☐	Integumentary (skin)	☐	☐	☐
Cardiovascular (heart, high blood pressure, cholesterol)	☐	☐	☐	Mental/Psychiatric	☐	☐	☐
				Blood/lymph	☐	☐	☐
Respiratory	☐	☐	☐	Endocrine (diabetes, thyroid, glands etc.)	☐	☐	☐
Nervous (neurological, nerve damage etc.)	☐	☐	☐	Allergic/Immunologic	☐	☐	☐
Genitourinary (genitals/kidney/bladder)	☐	☐	☐	Other health problems	☐	☐	☐

Please explain all yes answers: _____

***PLEASE LIST ALL CURRENT MEDICATIONS* you are taking** (including hormones or birth control pills): _____

CHECK IF NONE ☐ _____

Do you have…

Medication allergies? ☐ Yes ☐ No **If yes PLEASE LIST ALL** (including eye drops): _____

_____

Other allergies? ☐ Yes ☐ No To what? _____

Are you pregnant or nursing? ☐ Yes ☐ No

Do you use any of the following?

Tobacco ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No

Other substances ☐ Yes ☐ No If yes please explain: _____

Name of your family doctor: _____

FAMILY HISTORY

Has any family member had any of the following? ***(please check and provide relationship)***

Blindness	☐ Yes ☐ No	Relation _____	Retinal detachment	☐ Yes	☐ No	Relation _____
Diabetes	☐ Yes ☐ No	Relation _____	Cataract	☐ Yes	☐ No	Relation _____
Heart disease	☐ Yes ☐ No	Relation _____	Crossed or lazy eyes	☐ Yes	☐ No	Relation _____
High blood pressure	☐ Yes ☐ No	Relation _____	Glaucoma	☐ Yes	☐ No	Relation _____
Thyroid disease	☐ Yes ☐ No	Relation _____	Macular degeneration	☐ Yes	☐ No	Relation _____
Other medical: _____			Other eye disease: _____			

RETINAL EXAMINATION

Our doctors ***recommend*** that ALL PATIENTS have a periodic (routine) Retinal Examination as a preventive measure, with the new OPTOMAP retinal scanning laser. This laser takes a digital picture of the entire back of the eye in less then a second.

If you have a condition such as diabetes, high blood pressure, heart disease, headaches, high nearsightedness, cataracts, symptoms of flashing lights or floaters, glaucoma, macular degeneration, or a family history of any of these conditions, a Retinal Examination ***WILL BE REQUIRED*** as a part of your vision examination.

TRADITIONALLY, Retinal Examination required dilation of your pupils. Dilation involves placing medicated drops in your eye to enlarge the pupil size. This allows the doctor to examine the retina at the back of the eye, helping him to detect any disease that may be present. Side effects from these medicated drops include: sensitivity to light, slight blur of distance vision and the inability to focus or read up close. These symptoms last for approximately 3-4 hours. There is an additional fee for dilation of $15, which is covered by most insurance plans.

ALTERNATIVELY, we are pleased to offer the newest technology in Retinal Examination: The **OPTOMAP Retinal Exam.** The OPTOMAP allows our doctors to evaluate your retina ***without the side effects of pupil dilation***. Our doctors recommend the OPTOMAP Retinal Exam to everyone because it provides them with **a permanent digital image of your retina**, which in conjunction with computerized analysis, assists the doctor in the evaluation of any retinal changes from year to year. The fee for the OPTOMAP Retinal Exam is $40, which is in addition to your routine exam fee, and is not usually covered by insurance.

The staff or the doctors will be happy to discuss any questions you may have.

ALL PATIENTS MUST CHECK ONE

☐ I wish to have the OPTOMAP exam. ($40 – not covered by insurance)

☐ I wish to have my eyes dilated, if necessary. (usually covered by insurance)

☐ I wish to be rescheduled for a dilated retinal fundus examination. ($40 – not covered by insurance)

PLEASE SIGN AND DATE

Signature of patient/parent/guardian: _____ **Date:** _____ **Reviewed By:** _____ **Date:** _____

_____ **Date:** _____ **Reviewed By:** _____ **Date:** _____

_____ **Date:** _____ **Reviewed By:** _____ **Date:** _____