Patient History Form

Date: _____

Name: _____ E-Mail: _____ Male/Female

Address: _____ Birthday: _____ Employer: _____

_____ Phone: _____ Occupation: _____

What is the main reason for your visit today?

Complete Vision Insurance Info Below

Insurance: _____

ID Number: _____

Policy Holder's Name: _____

SSN: _____ Birthday: _____

Relationship to Policy Holder: _____

Do you wear glasses? ☐ Y ☐ N

If yes, do you wear them for: DIST, NEAR, BOTH

Do you wear contact lenses? ☐ Y ☐ N

Date of your last eye exam? _____

Date of your last medical exam? _____

Any allergies to medications? ☐ Y ☐ N

LIST: _____

_____

Do you suffer from headaches? ☐ Y ☐ N

Or season allergies? ☐ Y ☐ N

Are you taking any medications? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N

Do you see flashes of lights in your eyes? ☐ Y ☐ N

Do you see floating objects in your eyes? ☐ Y ☐ N

Do you suffer from temporary blackouts of your vision? ☐ Y ☐ N

LIST MEDS: _____

_____

_____

LIST EYE MEDS: _____

_____

_____

Do you suffer from:(check all that apply)

___ NONE
___ High Blood Pressure
___ Diabetes
___ Lung Disease
___ Cancer
___ Rheumatoid Arthritis
___ Sarcoidosis
___ Seizures
___ Multiple Sclerosis
___ HIV

Have your eyes ever suffered from:

___ NONE
___ Strabismus (eye turn)
___ Amblyopia (lazy eye)
___ Keratoconus
___ Glaucoma
___ Diabetic Retinopathy
___ Macular Degeneration
___ Dry Eyes
___ Iritis
___ Retinal Detachment
___ Retinal Disease
___ Optic Nerve Disease

Have you had previous eye surgery for:

___ NONE
___ Cataract
___ Retinal Detachment
___ Muscle Surgery
___ Trauma
___ Lasik/PRK
___ Foreign Body Removal
___ Other

Has anyone in your family suffered from:

___ NONE
___ Blindness
___ Glaucoma
___ Diabetes
___ Cataracts
___ Macular Degeneration
___ Keratoconus

Doctor Initials: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received or been offered the HIPPA Notice of Privacy Practices which describes the uses and disclosures of my protected health information by Eyecare of Florence and informs me of my rights with respect to my protected health information.

Patient or Guardian (if under 18 years old) Signature: _____ **Date:** _____

Informed Consent for the Dilated Fundus Exam

Medical research indicates that many people need their pupils dilated to rule out any eye disease that may cause the loss of their sight or worse. The dilated fundus examination is recommended for all patients who are new to the practice, diabetics, those with high blood pressure or lupus, have symptoms of flashes or floaters, those who have a history of retinal problems, highly near-sighted, those with a history of cancer, those who have experienced blunt head force trauma within 5 years, those who have unexplained headaches or visual acuity loss. It may be performed at your doctor's discretion.

It allows the doctor to obtain better views of the inside of the eye and is important for detecting changes in the eye and the rest of the body for things like diabetes, blood pressure, anemia, certain tumors and many other ocular and systemic pathologies. Without dilation our doctor will still look inside your eyes, however the view of all the structures is usually not as good.

What to expect:

Instillation: Mild stinging upon contact with your eye

10-30 Minutes: larger pupil sizes, light sensitivity, blurred near vision and slightly blurred distance vision

Total Effect: lasts for about 3 hours with gradual return to normal over the last hour

Please initial whether or not you wish to be dilated for your exam today.

_____ I DO NOT wish to be dilated today.

_____ I wish to be dilated today.

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature: _____ Date: _____