Patient History Form

Reason for examintaion today:

Do you wear contacts/Are you interested in contacts?

Are you interested in Lasik?

List all current illnesses, injuries, or recent surgery:

List all current medications you are taking:

Allergies to medications/ Any other allergies:

Our office utilizes the Optos Retinal Imaging system, which enables our eye care professionals to capture an ultra-wide veiew of the retina. This advanced technology allows for earlier detection and more effective monitoring of a variety of eye conditions, including, diabetic retinopathy, glaucoma, and macular degeneration. The imaging process is quick, painless, and may serve as an alternative to tradtional dilation in many cases.

Please note that Optos Imaginng is not a covered benefit under most insurance plans and requires an out of pocket fee of $39. Patients may choose to proceed with the Optos Imaging, traditional dilation, or neither - though declining both is not recommended for maintaing optimal eye health. Please choose one below.

Optos Imaging ($39): _____ Traditional Dilation ($0): _____ Decline Both: _____

Visual symptoms, please check all that apply to you:

_____ Headaches
_____ Glare/Light Sensitivity
_____ Tired Eyes
_____ Burning
_____ Dryness
_____ Excessive Tearing/Watering
_____ Eye pain or Soreness
_____ Foreign Body Sensation
_____ Infection of the Eye
_____ Loss of Vision

_____ Itching
_____ Mucous Discharge
_____ Ptosis (Drooping Eyelid)
_____ Redness
_____ Blurred Vision Distance
_____ Blurred Vision Near
_____ Distorted Vision (halos)
_____ Double Vision
_____ Floaters or Spots

Yourself	Family Member		Family member's relation to you
_____	_____	Respiratory Problems (asthma, emphysema, etc.)	_____
_____	_____	Gastrointestinal	_____
_____	_____	Genital, Kidney, Bladder	_____
_____	_____	Skin (acne, warts, skin cancer, etc.)	_____
_____	_____	Neurological (Multiple Sclerosis, etc.)	_____
_____	_____	Psychiatric (anxiety, depression, insomnia)	_____
_____	_____	Allergic/Immunologic (hay fever, lupus, etc.)	_____

Ocular Medical and Family Medical History, please check all that apply to you:

Yourself	Family Member		Family member's relation to you
_____	_____	Amblyopia (lazy eye)	_____
_____	_____	Blindness	_____
_____	_____	Cataracts	_____
_____	_____	Color Blindness	_____
_____	_____	Glaucoma	_____
_____	_____	Macular Degeneration	_____
_____	_____	Retinal Detachment	_____
_____	_____	Strabismus (eye turn)	_____
_____	_____	Arthritis	_____
_____	_____	Cancer	_____
_____	_____	Diabetes	_____
_____	_____	Heart Disease	_____
_____	_____	High Blood Pressure	_____
_____	_____	Kidney Disease	_____
_____	_____	Lupus	_____
_____	_____	Stroke	_____
_____	_____	Thyroid Disease	_____
_____	_____	Other	_____

Have you been exposed to any of the following diseases?: HIV: ◯ Herpes Simplex: ◯ Syphilis: ◯ Chlamydia: ◯

Do you use a computer?: Yes ◯ No ◯
Frequency?: _____

Do you drive?: Yes ◯ No ◯

Do you have difficulty seeing while driving at night?: Yes ◯ No ◯

Do you drink alcohol?: Yes ◯ No ◯
Frequency?: _____

Do you smoke?: Yes ◯ No ◯
Frequency?: _____

Have you worn contacts in the past?: Yes ◯ No ◯

Are you currently wearing contacts?: Yes ◯ No ◯
If yes, what brand/type of contact lenses?:
_____

Please Note: Contact lens services/measurements are not included in a comprehensive eye exam. A comprehensive eye exam includes a full eye health check with glaucoma testing, visual field screening, refraction, and dialation as necessary. **Our contact lens diagnostic evaluation and fitting fees range from $75 to $135 depending on your history with contact lenses and the type of contact lenses you are prescribed.**

I would like a contact lens evaluation and prescription today.: Yes ◯ No ◯

Acknowledgement of Receipt of Privacy Notice:

I acknowledge that I have been offered a copy of Dr. Jeffrey Holland's Notice of Privacy Practices. I have accepted the notice or declined to accept the notice.

Your Name (print) _____

Signature of Patient or authorized representative _____

Date