

WELCOME TO *Image* Eye Care

PATIENT HISTORY FORM						EXAM DATE	/ /		
LAST NAME			FIRST NAME			<input type="checkbox"/> M <input type="checkbox"/> F	BIRTH DATE	/ /	
ADDRESS			CITY			STATE	ZIP CODE		
CELL PHONE	()		OTHER PHONE	()		SOCIAL SEC#			
EMPLOYER					OCCUPATION				
REFERRED BY					EMAIL ADDRESS				
INSURANCE INFORMATION									
VISION INSURANCE PLAN			VISION ID #			MEDICARE #			
MEDICAL INSURANCE PLAN			RELATIONSHIP TO PATIENT:	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD (CHECK ONE)					
INSURED ID#			INSURED DOB:	/ /		INSURED SS#			
OCULAR AND MEDICAL HISTORY									
WHAT IS THE REASON FOR TODAY'S VISIT?									
AGE OF PRESENT GLASSES			YRS	WOULD YOU LIKE NEW GLASSES?			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> IF NECESSARY		
LAST EYE EXAM	/ /		FROM DOCTOR			PREVIOUS PATIENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENTS, PARENTS, BROTHER OR SISTER) HAVE ANY OF THESE CONDITIONS?									
	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE	YES	NO
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU SEE DOUBLE?	<input type="checkbox"/> <input type="checkbox"/>
HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CATARACTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT HEADACHES?	<input type="checkbox"/> <input type="checkbox"/>
THYROID DIS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RETINAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BRIGHT LIGHTS BOTHER YOU?	<input type="checkbox"/> <input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYE SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU HAVE DRY EYES?	<input type="checkbox"/> <input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EYE INJURY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT?	<input type="checkbox"/> <input type="checkbox"/>
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PRIMARY CARE DR.	<input type="checkbox"/> <input type="checkbox"/>
PLEASE EXPLAIN ANY POSITIVE FINDINGS:									
PLEASE LIST YOUR PRESCRIPTION MEDICATIONS:									
DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? IF YES, PLEASE EXPLAIN.									
CONTACT LENS INFORMATION									
DO YOU CURRENTLY WEAR CONTACT LENSES?	<input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHAT TYPE?						
HAVE YOU EVER WORN CONTACT LENSES?	<input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHAT TYPE?						
ARE YOU INTERESTED IN A CONTACT LENS PRESCRIPTION?	<input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHAT TYPE?						
SPECIAL TASKS INFORMATION				SMOKING HISTORY			RACE		
DO YOU PARTICIPATE IN ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)				<input type="checkbox"/> NEVER SMOKED <input type="checkbox"/> WHITE <input type="checkbox"/> FORMER SMOKER <input type="checkbox"/> ASIAN <input type="checkbox"/> OCCASIONALLY <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> CURRENT EVERYDAY SMOKER <input type="checkbox"/> HISPANIC <input type="checkbox"/> PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN					
<input type="checkbox"/> NIGHT DRIVING									
<input type="checkbox"/> FINE, DETAILED WORK (SEWING/ NEEDLEPOINT)									
<input type="checkbox"/> EXTENDED READING									
<input type="checkbox"/> COMPUTER USE -- HOW MANY HOURS/DAY?									
<input type="checkbox"/> DANGEROUS WORK ENVIRONMENT (SAFETY Rx)									
FUNDUS EXAM									
YOU ARE URGED TO HAVE A THOROUGH RETINAL EXAM IF YOU HAVE OR ARE EXPERIENCING ANY OF THE FOLLOWING:									
<input checked="" type="checkbox"/> DIABETES	<input checked="" type="checkbox"/> SYMPTOMS OF FLASHES OF LIGHTS OR FLOATERS		<input checked="" type="checkbox"/> PERSONAL OR FAMILY HISTORY OF GLAUCOMA						
<input checked="" type="checkbox"/> HIGH BLOOD PRESSURE	<input checked="" type="checkbox"/> FREQUENT OR SEVERE HEADACHES		<input checked="" type="checkbox"/> PERSONAL OR FAMILY HISTORY OF MACULAR DEGENERATION						
<input type="checkbox"/> YES, I WOULD LIKE TO HAVE MY EYES DILATED.									
PLEASE BE AWARE YOU WILL EXPERIENCE BLURRY VISION AND LIGHT SENSITIVITY FOR APPROXIMATELY 6 HOURS.									
<input type="checkbox"/> I WOULD PREFER RETINAL PHOTOS.									
OUR FUNDUS CAMERA WILL TAKE HIGH RESOLUTION PICTURES INSIDE YOUR EYES. YOU WILL BE ABLE TO REVIEW YOUR PHOTOS AND EYE HEALTH WITH OUR DOCTOR. THIS IS A NON-INVASIVE PROCEDURE THAT WILL MOST LIKELY NOT REQUIRE A DILATION, FOR A NOMINAL FEE OF \$20.00.									
<input type="checkbox"/> NO, I ASSUME THE RESPONSIBILITY OF HAVING MY EYES EXAMINED WITHOUT A DILATION OR RETINAL PHOTOS.									
** IF PATIENT IS A MINOR, PARENT MUST SIGN.				_____			DATE		
				AUTHORIZED SIGNATURE					