Patient History Form

PLEASE PRINT Today's Date_____

Patient Name (FIRST, MI, LAST) _____

Address _____

City / State / Zip _____

Birth Date _____ Male ___ Female ___ Occupation _____ Employer _____

Phone _____ Email _____

Were you referred to the Spectacle Shoppe? Y ___ N ___ If yes, who may we thank for the referral? _____

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? _____

Do you have allergies to medication? Y___ N___

LIST:_____

_____

_____

Are you pregnant? Y___ N___

Do you see flashes of light in your eye? Y__ N__

Do you see floating objects in your eyes?Y__ N__

If yes, how long have they been present? _____

Are you taking any medications? Y___ N___

LIST MEDS:

_____

_____

_____

_____

LIST EYE MEDS:

_____

_____

_____

Do you suffer from:

- ❑ **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

Acknowledgement of Receipt of Notice of Privacy Practices

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

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

X_____

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, lupus, symptoms of flashes or floaters, history of retinal problems, highly near-sighted, history of cancer, experience with blunt head trauma within 5 years, unexplained headaches, unexplained visual acuity loss, or at your doctor's discretion.

The drops used, require 20 minutes to take effect and may keep your eyes dilated for up to 4 hours. Near vision may improve within 2 hours. Dilation will cause your vision to be temporarily blurry, and your eyes will be sensitive to sunlight, possibly making some of your days activities difficult. If necessary, your dilation can be rescheduled for a more convenient time.

If you experience ANY PAIN IN OR AROUND YOUR EYES, HAZY VISION OR A SICK FEELING, PLEASE CONTACT ONE OF OUR DOCTORS AS SOON AS POSSIBLE.

Please check one:

___ I want to have the dilation today.

___ I DO NOT want the dilation today.

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

X_____

PLEASE CONTINUE ON THE BACK....

REVIEW OF SYSTEMS - *PLEASE CHECK ALL THAT APPLY TO YOU*

- ❑ **VISION PROBLEMS** (POOR VISION EVEN WITH GLASSES/CONTACTS, OR EYE PAIN)
- ❑ **CONSTITUTION** (EXCESSIVE FATIGUE, UNEXPLAINED WEIGHT LOSS)
- ❑ **CARDIOVASCULAR** (HIGH BLOOD PRESSURE, HEART PROBLEMS)
- ❑ **EAR / NOSE / THROAT PROBLEMS** (SINUS PROBLEMS, HEARING LOSS)
- ❑ **RESPIRATORY PROBLEMS** (ASTHMA, COPD)
- ❑ **GASTROINTESTINAL PROBLEMS** (CROHN'S, ULCERATIVE COLITIS)
- ❑ **GENITOURINARY PROBLEMS** (PAIN / BLOOD IN URINE)
- ❑ **MUSCULOSKELETAL PROBLEMS** (ARTHRITIS, JOINT PAIN)
- ❑ **INTEGUMENTARY** (SKIN PROBLEMS, RASHES, ROSACEA)
- ❑ **NEUROLOGICAL PROBLEMS** (NUMBNESS, PARALYSIS, MIGRAINES, MS)
- ❑ **PSYCHIATRIC PROBLEMS** (ANXIETY, DEPRESSION, ETC.)
- ❑ **ENDOCRINE PROBLEMS** (DIABETES, THYROID TROUBLES)
  - ❑ HOW LONG HAVE YOU HAD DIABETES?_____
  - ❑ WHAT WAS YOUR LAST HbA1C? _____
- ❑ **HEMATOLOGIC / LYMPHATIC DISEASE** (ANEMIA, BLEEDING)
- ❑ **ALLERGIES** _____

PLEASE CHECK THIS BOX IF NONE OF THE ABOVE APPLY ☐

DOCTOR EXAM NOTES: