WELCOME TO OUR OFFICE

PLEASE COMPLETE THE FOLLOWING:

Today's Date: _____/_____/_____

PATIENT INFORMATION		Gender:			
LAST NAME	FIRST NAME	MIDDLE		DATE OF BIRTH	
HOME ADDRESS	CITY	STATE	ZIP CODE	SOCIAL SECURITY NUMBER	
MOBILE PHONE	ALTERNATIVE	EMAIL ADDRESS			
EMPLOYER (OR SCHOOL)	OCCUPATION (OR GRADE)	HOBBIES/SPECIAL INTERESTS			
HOW DID YOU HEAR ABOUT OUR OFFICE?					
IF THE PATIENT IS UNDER 18 YEARS OF AGE					
NAME OF PARENT/GUARDIAN	PHONE	RELATION TO PATIENT			
EMERGENCY CONTACT					
NAME OF EMERGENCY CONTACT	PHONE	RELATION TO PATIENT			
MEDICAL INFORMATION					
PRIMARY CARE PHYSICIAN	DATE OF LAST PHYSICAL	LAST EYE DOCTOR		DATE OF LAST EYE EXAM	
MEDICAL INSURANCE COVERAGE					
NAME OF MEDICAL INSURANCE	POLICY HOLDER (EMPLOYEE)	POLICY HOLDER BIRTHDATE		RELATION TO PATIENT	
VISION INSURANCE COVERAGE					
NAME OF VISION INSURANCE	POLICY HOLDER (EMPLOYEE)	POLICY HOLDER BIRTHDATE		RELATION TO PATIENT	

DIGITAL RETINAL IMAGING - Introducing Optos

Hazel Family Eyecare has always used advanced technology to monitor early signs of ocular disease within your eye and the layers beneath your retina. Since early diagnosis is critical, Dr. Fowler and Dr. Thomas strongly recommend our complete wellness exam every year for diagnostics and comparative documentation. These costs are typically not covered by insurance. Please select one.

□ **$39.00 - Optos Retinal Image only**
Opto**s** is a quick photo that captures more than 80% of your retina in a single panoramic image, something no other retinal imaging device is capable of. This larger capture is clinically important as the peripheral retina more frequently has thinning and tears that can lead to a retinal detachment. Optos also aids in early detection of systemic diseases such as hypertension, diabetes, some cancers, stroke and autoimmune disorders. **Likely, dilation will be eliminated saving you time, blurriness and light sensitivity.** (Certain circumstances may still require dilation.)

□ **$39.00 - Retinal Scanning only with OCT (similar to an MRI)**
OCT (Optical Coherence Tomography) is an imaging exam that utilizes light waves to scan the macular area in the back of the eye, providing a cross-sectional view of the nine layers of the retina**. The OCT detects early signs of macular degeneration**, fluid accumulation and central retinal detachments which may aid with early treatment options.

□ **$55.00 – As recommended, I select both services** for the most comprehensive overall eye health exam.

□ Contrary to recommendation, I decline the options above.

DO YOU CURRENTLY:	ARE YOU INTERESTED TODAY IN:
☐ WEAR GLASSES? IF SO, HOW OLD ARE THEY: _____	☐ PURCHASING NEW EYEWEAR
☐WEAR POLARIZED SUNGLASSES? IF SO, HOW OLD ARE THEY: _____	☐ TRYING CONTACT LENSES
☐WEAR CONTACT LENSES? IF SO, WHAT BRAND: _____	☐ LEARNING ABOUT REFRACTIVE SURGERY

YOUR VISUAL FUNCTION: Please check all that apply to you	
☐ WORK ON COMPUTERS UNDER FLOURESCENT LIGHTING	☐ CONTACT LENSES GET DRY AT LEAST ONCE A DAY
☐ SPEND TIME PLAYING OUTDOOR ACTIVITIES	☐ CONTACT LENSES ARE NOT AS CLEAR AS DESIRED
☐ ENJOY BOATING OR OTHER WATER SPORTS	☐ EXPERIENCE GLARE WHILE DRIVING AT NIGHT
☐ EYES ARE SENSITIVE TO SUNLIGHT	☐ EXPERIENCE EYE STRAIN WHILE USING THE COMPUTER
☐ DRIVE TO OR FROM WORK DIRECTLY FACING THE SUN	☐ READ BOOKS/STUDY FOR LONGER THAN 2 HOURS A DAY
☐ OCCUPATION THAT INVOLVES POSSIBILITY OF EYE INJURY	☐ WOULD LIKE INFO ON THINNER/LIGHTER LENSES

HAVE YOU EVER HAD:

☐ CATARACT SURGERY EYE MUSCLE SURGERY RETINALSURGERY LASIK SURGERY OTHER EYE SURGERY

IF SO, WHICH EYE WHEN:

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS:

☐ BLURRED VISION	☐ DRYNESS	☐ FLOATERS IN VISION	☐ SANDY FEELING
☐ BURNING	☐ EXCESSIVE TEARING	☐ GLARE SENSITIVITY	☐ SUDDEN VISION LOSS
☐ DOUBLE VISION	☐ EYE PAIN/SORENESS	☐EYE/EYELID INFECTION	☐ LOSS OF PERIPHERAL VISION
☐ DROOPING EYELID	☐ FLASHES OF LIGHT	☐ ITCHING	☐ OTHER

VISION HISTORY

Check appropriate boxes if YOU or your blood RELATIVES have:

F = Father M = Mother S = Sibling GP = Grandparent(s)

	YOU	Family Member
Amblyopia/Lazy eye	☐	F M S GP
Blindness	☐	F M S GP
Cataracts	☐	F M S GP
Color blindness	☐	F M S GP
Crossed/Turned eyes	☐	F M S GP
Diabetic retinopathy	☐	F M S GP
Glaucoma	☐	F M S GP
Herpes eye disease	☐	F M S GP
Keratoconus	☐	F M S GP
Macular degeneration	☐	F M S GP
Retinal detachment	☐	F M S GP
Traumatic eye injury	☐	F M S GP
Other eye condition	☐	F M S GP

SOCIAL HISTORY

Do you smoke? NO YES _____pack per day

Do you drink? NO YES _____drinks per wk

FEMALES, ARE YOU:

☐ Pregnant _____months/weeks ☐ Nursing

PLEASE LIST ALL ALLERGIES:

PLEASE LIST ALL CURRENT MEDICATIONS:

MEDICAL HISTORY

Check appropriate boxes if YOU or your blood RELATIVES have:

F = Father M = Mother S = Sibling GP = Grandparent(s)

	YOU	Family Member
Allergies	☐	F M S GP
Arthritis	☐	F M S GP
Blood disease (anemia)	☐	F M S GP
Breathing problems	☐	F M S GP
Cancer	☐	F M S GP
Cardio (heart, carotid)	☐	F M S GP
High Cholesterol	☐	F M S GP
Collagen (lupus)	☐	F M S GP
Diabetes	☐	F M S GP
Fatigue	☐	F M S GP
Fever blister/cold sore	☐	F M S GP
Gastro (stomach, colon)	☐	F M S GP
Genital, kidney, bladder	☐	F M S GP
Headache/Migraine	☐	F M S GP
Hearing Impairment	☐	F M S GP
Herpes	☐	F M S GP
High Blood Pressure	☐	F M S GP
HIV / Aids	☐	F M S GP
Hormonal/Thyroid	☐	F M S GP
Nose, Sinus Throat	☐	F M S GP
Psych (anxiety, depression)	☐	F M S GP
Resp.(asthma, emphysema)	☐	F M S GP
Sex. Transmitted Disease	☐	F M S GP
Skin (acne, eczema)	☐	F M S GP
Weak/numb leg/arm	☐	F M S GP
Weight changes, sudden	☐	F M S GP