



PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name _____ First Name _____ MI _____
 Address _____ City _____ State _____ Zip _____
 Work Phone _____ Home Phone _____
 Date of birth _____ Occupation _____ Email _____
 Emergency Contact Name _____ Phone Number _____
 Date of Last Eye Exam _____ Dilated? Yes / No Referred By: _____
 Primary Vision Coverage _____ Secondary Coverage _____

How would you prefer us to remind you of your scheduled appointment?

Email Phone Call

Medical Information

What is your general health? _____

Do you have problems with any of these systems? (Please circle yes or no.)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____

Diabetes Yes/No Type _____ Date of diagnosis _____

Allergies to Medication Yes/No Which? _____ Reactions? _____

Other health problems _____

Current medication(s) _____

Have you had any operations? Yes/No Kind? _____ When? _____

Name of family doctor _____

Date of last visit _____ Date of last tetanus shot _____

Family History

High blood pressure Yes/No Relation _____ Macular degeneration Yes/No Relation _____

Diabetes Yes/No Relation _____ Retinal detachment Yes/No Relation _____

Glaucoma Yes/No Relation _____ Cataracts Yes/No Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? _____

Have you had any eye operations? Yes/No Type _____ Date _____

Have you had an eye injury? Yes/No Kind _____ Date _____

Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No

Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred vision? Yes/No

Do you wear glasses? Yes/No Contact lenses? Yes/No Type _____

Additional information _____

Doctor Use Only

Reviewed by _____ No changes Date _____

Reviewed by _____ No changes Date _____

Reviewed by _____ No changes Date _____

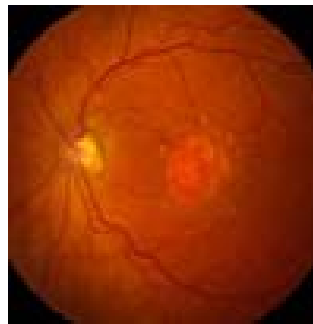
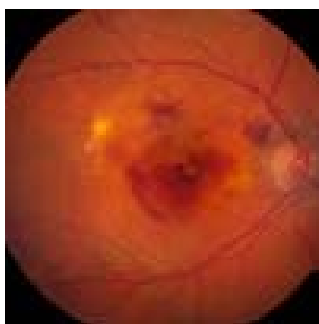
DIGITAL RETINAL SCREENING CONSENT

Our office offers high resolution retinal photography, which uses a computer-integrated digital imaging system to record a detailed view of the retina. This image provides an excellent reference point for future comparisons and records any changes.

We recommend that **all our patients** have this test. It is especially important for those with a history of and/or a family history of:

- ✓ Diabetes
- ✓ High blood pressure
- ✓ Glaucoma
- ✓ Macular Degeneration
- ✓ Retinal diseases
- ✓ Flashing lights
- ✓ Decreased or distorted vision
- ✓ A strong glasses prescription

Even if you see well, many retinal conditions **do not produce symptoms** such as pain or blurred vision. Retinal photography helps in early detection of retinal problems to avoid vision loss and preserve superior eye health.



The fee for this additional part of your eye exam is \$39. In most cases, this test is not covered under your medical or vision insurance. Upon request, this office will advise you of your coverage, and you may be required to submit a receipt for reimbursement from your insurance provider.

_____ **Yes, I want to have retinal photos taken as part of my eye exam.**

_____ No, I decline the recommendation to have retinal photos taken.

Signature: _____ Date: _____