MEDICAL HISTORY FORM

Patient Name: _____ Birth Date: _____
LAST NAME FIRST NAME MIDDLE NAME

Gender ☐M ☐F Best Phone Number: _____ E-mail: _____ @ _____

Reasons to visit the optometrist today: Please Describe: _____

☐Routine Eye Exams ☐Sudden changes in Vision ☐Blurry vision ☐Double vision ☐ Eye Injuries or Infections

Do you need to change your home address? ☐Yes ☐No **If yes, please complete a Change of Address, below.**

New Address: _____City: _____ Zip Code: _____

Note: If you want to share your health information with family members or anyone you authorize, please let us know.

Do **you want to** share **your information with any member of your family?** ☐**Yes** ☐**No**

If yes, please indicate who: _____
LAST NAME FIRST NAME RELATIONSHIP BIRTHDATE

Do you or any member of your immediate family have any of the following? If yes, please mark the box below.

You	Family Bloodline	You	Family Bloodline
☐ Diabetes type 1	☐ Diabetes type 1	☐ Ocular Hypertension	☐ Ocular Hypertension
☐ Diabetes type 2	☐ Diabetes type 2	☐ Cataracts	☐ Cataracts
☐ Glaucoma	☐ Glaucoma	☐ Macular Degeneration	☐ Macular Degeneration
☐ High Blood Pressure	☐ High Blood Pressure	☐ **Any other conditions(s) not listed:**	
☐ High Cholesterol	☐ High Cholesterol		
☐ Diabetic Retinopathy	☐ Diabetic Retinopathy		

Do you take medication? ☐Yes ☐ No	**Name of medication(s):**	**For treatment of what condition?**	**How often is it used?**

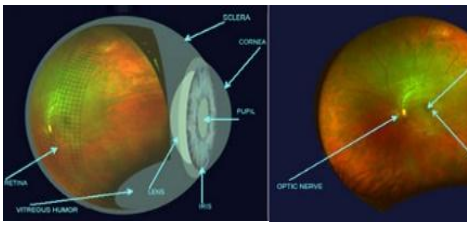
Have you ever suffered eye injury, or had any eye surgery? ☐Yes ☐No

If yes, please indicate briefly: _____

Who is your primary care physician? _____

Primary physician phone number? _____ Fax if any available: _____

Note:



optomap®
ultra-widefield retinal imaging

1. **Optomap®** is a high-resolution, wide-field photograph of the retina.
2. It is recommended by your eye doctor.

The procedure is $10.00 and is not covered by your insurance.
Optomap captures a significantly wider view of the retina.

Another option is **Dilation:** It is the use of eye drops that temporarily enlarge the pupil.
This procedure is a Standard part of a Comprehensive Eye Exam.
Note:
Blurry vision and light sensitivity are common side effects of dilation and usually subside within a few hours.

Payment is expected at the time of service, which includes co-payment, co-insurance, and non-covered charges.
By signing below, I acknowledge that I have fully read and understood.

Name (Print): _____ Signature_____ Date: _____