

WELCOME TO EAST METRO EYECARE

CURRENT MEDICATIONS

PATIENT INFO

Today's Date _____

Last Name _____ First _____ MI _____

Date of Birth _____ Age _____ Sex M F

email address _____

What is the major purpose of this visit?

Are you having problems with your current contacts or glasses?

Please provide all medications including eye drops and vitamins, or allow a staff member to photocopy your personal list.

MEDICAL HISTORY

Patient Medical History

Family Physician _____

Date of Last Physical Checkup _____

Are you pregnant/ nursing YES NO

Do you use: Cigarettes Alcohol Tobacco Other

Do you have any allergies to medications? NO YES

Have you ever been diagnosed or treated for . . . ?

<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Allergies
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Skin Problems	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Cancer	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Kidney
<input type="checkbox"/> Nerves	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Other

Very Important! New Patients Only :

Who may we thank for referring you today

Are you planning on purchasing new glasses?
 YES NO UNSURE

Are you interested in ordering Contacts online?
 YES NO UNSURE

GLAUCOMA

Would you like to have a **Glaucoma screening** using the latest technology that aids in diagnosing glaucoma to help decrease the likelihood of irreversible blindness by allowing us to detect and begin treatment earlier. Are over is **HIGHLY** recommended if you have a family history of glaucoma, are over age 40, African-American, diabetic, are near-sighted or have had previous eye surgery or injury. There is a **\$10 charge** for this procedure.

I elect to have this \$10 procedure I decline this procedure

CONTACTS LAST EXAM

Patient Eye History

Date of Last Eye Exam _____

By Whom ? _____

Do you . . . ?

Work at a computer?
 Have prescription sunglasses?
 If you wear bifocals, do the lines or head tilting bother you?

Have you ever tried contact lens? YES NO Solutions used _____

Do you currently wear contacts? YES NO

What kind ? _____ Are you satisfied with the vision and comfort? Y N

EYE HISTORY

Have you ever had or been diagnosed with any of the following:

<input type="checkbox"/> Cataracts	<input type="checkbox"/> Corneal Abrasion	<input type="checkbox"/> Eye infection	<input type="checkbox"/> Eye surgery
<input type="checkbox"/> Iritis / Uveitis	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Eye injury	<input type="checkbox"/> Blurry Vision
<input type="checkbox"/> Lazy eye	<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Burning Sensation
<input type="checkbox"/> Floaters /Spots	<input type="checkbox"/> Trouble in Dim Light	<input type="checkbox"/> Crossed Eye	<input type="checkbox"/> Grittiness
<input type="checkbox"/> Tearing	<input type="checkbox"/> Sunlight Sensitivity	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Headaches
<input type="checkbox"/> Itchiness	<input type="checkbox"/> Uncomfortable glasses	<input type="checkbox"/> Dryness	<input type="checkbox"/> Flashes of Light

Family Medical / Eye History

Is there a family history of any of the following?

<input type="checkbox"/> Retinal Detachment	Relationship _____	<input type="checkbox"/> Blindness	Relationship _____
<input type="checkbox"/> Macular Degeneration	_____	<input type="checkbox"/> Cataracts	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Diabetes	_____

Doctor's Initials _____

The information in this confidential case history is critical to the evaluation of your vision & health

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

RELEASE

I AUTHORIZE THE PROFESSIONAL OFFICE OF EAST METRO EYECARE,PC TO RELEASE HEALTH INFORMATION TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY TO PROVIDE MEDICAL CARE. THIS AUTHORIZATION CAN BE REVOKED AT ANY TIME UNLESS WE HAVE ALREADY ACTED IN RELIANCE UPON THE AUTHORIZATION. I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Signature _____