



### GENERAL HEALTH HISTORY

Diabetes	Yes	No	Family	Heart Problems	Yes	No	Family	Are you pregnant?	Yes	No
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink?	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	List: _____							

Known Drug Allergies Yes No If yes, list: \_\_\_\_\_  
Name of family doctor \_\_\_\_\_ Last Physical \_\_\_\_\_

### EYE HISTORY

Reason for Visit:  Glasses  Contact Lenses  Problem  Lasik consult  Other \_\_\_\_\_

Any History of:

	Yes	No		Yes	No		Yes	No	Family
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Burn/Itch/Tear	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye injury	<input type="checkbox"/>	<input type="checkbox"/>	Eye infection	<input type="checkbox"/>	<input type="checkbox"/>	Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Macular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light flashes	<input type="checkbox"/>	<input type="checkbox"/>	Using drops	<input type="checkbox"/>	<input type="checkbox"/>	Degeneration			

Last eye exam \_\_\_\_\_ Last eye doctor \_\_\_\_\_

### PUPIL DILATION

Dilation is standard procedure for each comprehensive eye exam. Dilating drops last about 4 to 6 hours and allow the doctor a **more thorough examination of your retina** (back of the eye). Dilation can assist in early detection of glaucoma, cataracts, retinal and neurological, and can assist in diagnosing causes of some headaches. Dilation may also assist in determining the final glasses prescription, especially in young children. **We strongly suggest that all new patients be dilated.**

I **do** want this procedure. Signature \_\_\_\_\_  
 I **do not** want this procedure. Signature \_\_\_\_\_

### VISUAL FIELD SCREENING

A sophisticated computerized instrument can now allow us to provide a more thorough analysis of the health of the entire visual system from the eye to the back of the brain by measuring the visual field. Visual field testing can assist us in early detection of glaucoma, retinal problems, neurological diseases (such as brain tumors and optic nerve disease), and enable us to better diagnose causes of headaches, migraines, or vertigo. We strongly recommend that our patients receive this test as part of their comprehensive visual analysis. **There is an additional \$10 fee for this procedure.**

I **do** want the visual field screening.  
 I **do not** want the visual field screening.

### AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me (or my child) or during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I have read and understand Today's Visions Refund policy.

**X** \_\_\_\_\_  
**SIGNATURE OF PATIENT (Or parent if a minor)** **DATE**