Information Update

Name _____

D.O.B. _____ Pharmacy/Location _____

Have there been any changes in your medical history in the last year?
If yes, please list.
None ❑

_____

_____

Have there been any changes in your family medical history?
None ❑

_____

_____

Medications can affect your vision. Please list **ALL** medications including eye drops, hormones, and over the counter medications, vitamins and supplements
None ❑

_____

_____

_____

_____

Please list all medication allergies.
None ❑

_____

_____

_____

Tobacco Use?
Never ❑ Former Smoker ❑ Smokeless Tobacco ❑
Current Smoker ❑ Packs per Day _____

Alcohol Use?
None ❑ Social use only ❑ 1-2 drinks daily ❑
Above average use ❑ Alcohol dependence ❑

Have there been any changes in address, phone #, etc.
None ❑

_____

_____

Primary Care Doctor:

_____

Phone # to reach you during business hours.

_____

May we text you appointment reminders?
Yes ❑ No ❑

Cell #

_____

E-mail address

_____

Are you wearing contacts?

Yes ❑ No ❑

The information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of changes in my medical status. I authorize the Doctor/Staff to perform any necessary services, such as dilation, that may be needed during diagnosis and treatment with my informed consent.

_____ _____

Signature Date

optos®

Retinal Exam

At **Drs. Coulter, McRoy & Associates, PC**, we pride ourselves on providing you with the best possible standard of care. Because of this we offer the Optomap® retinal exam. This non-invasive imaging test allows the doctor to see a much more detailed view of the retina than with traditional methods. The image becomes a permanent part of your medical file allowing the doctor to make important comparisons year over year. In many cases there will not be a need to dilate after this process. If the doctor determines that there is a need for dilation and/or more detailed retinal view, this will be discussed during your exam.

These images will help see early signs of many ocular conditions and systemic diseases such as:

- Glaucoma
- Age related macular degeneration
- High blood pressure
- Diabetes
- Retinal holes or detachments

The $29.00 fee for this procedure is a service that is not covered by insurance. Any questions you have about the Optomap® Retinal Exam can be directed to your doctor during your examination. The doctor strongly believes that either traditional dilation OR the Optomap® Retinal Exam is an essential part of your comprehensive eye health exam and recommends it for all patients once per year.

( ) **YES:** I understand the importance of having the OPTOMAP Retinal Exam and would like to have it performed ($29 fee).

( ) **NO:** I elect to have my eyes dilated (no additional charge). I understand that it will cause light sensitivity and may blur my vision for about 2-4 hours. Also, I should not operate heavy equipment or drive an automobile until I feel safe to accomplish these tasks. Any lasting affects such as redness and swelling or ocular pain should be reported as soon as possible.

Patient signature: _____ date: _____

Member American Optometric Association

Drs. Coulter, McRoy & Associates, P.C

MORRI COULTER, O.D.
RICA PATNAIK McROY, O.D.
DOCTORS OF OPTOMETRY

Parent Questionnaire

Child's name: _____ Date of Birth: _____ Grade: _____
School: _____ Reading Level: _____ Teacher: _____

Please check if your child reports or if you or your child's teacher have noticed any of the following:

_____ Skips or rereads letters or words.
_____ Complains of blurred vision during reading or writing.
_____ Complains of blurred distance vision after much near work.
_____ Complains of headaches associated with visual tasks.
_____ Complains of print "running together" or "jumping".
_____ Reports sensation of eyes "not working together".
_____ One eye turns in, out, up or down at any time.
_____ Experiences unusual fatigue after visual concentration.
_____ Reports pain around or in the eyes at any time.
_____ Reddened eyes or lids.
_____ Excessive tearing of eyes or rubs eyes frequently.
_____ Blinks excessively.
_____ Frowns, scowls, or squints with visual tasks.
_____ Tilts or turns head while reading.
_____ Closes or covers one eye in bright light or during visual tasks.
_____ Moves head forward or backward while looking at a distant object.
_____ Avoids close work.
_____ Holds book too closely.
_____ Reversals when reading (was/saw, on/no).
_____ Uses finger as a marker when reading.
_____ Transposition of letters or number (21 for 12).
_____ Poor writing or handwriting.
_____ Difficulty in copying from blackboard to paper.

Developmental History

1. Were there any complications with pregnancy or at birth? If yes, please explain: _____
2. Was there any use of alcohol, drugs, medication, or cigarettes during pregnancy? _____ If yes, please explain: _____
3. At what age did your child walk? _____
4. Is speech adequate now? _____
5. Did the child have any early behavioral problems (temper tantrums, self-destructive behavior, difficulty sleeping, etc.)? If yes, please explain: _____
6. Does your child frequently walk into things or trip? _____

General Health and Behavior

1. Have there been any severe childhood illnesses, high fever, injury or physical impairment? _____ If yes, please explain: _____
2. Has the child had any ear infections? _____ If yes, please indicate how often and whether a treatment was received: _____
3. Has your child ever had a neurological evaluation? _____ If yes, please indicate when and the results. _____

Please turn sheet over to continue

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4. What medications (such as penicillin, sulfonamide drugs) have been given and for what?

_____

5. Has your child ever had a vision, speech or language evaluation or therapy? _____ if yes, please indicate when and the results: _____
6. Does your child exhibit any tension behavior such as nail biting, eye blinking or rubbing, tantrums, tongue chewing or lip biting, etc? _____ If so, when? _____ Do these tension behaviors seem related to school, schoolwork or television? _____
7. What are your child's special interests? _____
8. Is your child good with his or her hands? _____
9. Does he or she like to participate in sports activities? _____
10. Does your family read alot? _____
11. Is there a family history of significant reading, writing, or spelling difficulties? _____ Who? _____ Describe: _____
12. Is there a family history of hyperactivity, attention problems, or speech difficulties? _____ Who? _____ ____ Describe: _____

Educational Information

1. At what age did your child begin nursery school? _____ Kindergarten? _____ First Grade? _____
2. Has your child ever repeated a grade? _____ If yes, which: _____
3. Has your child had any evaluations (psychological, special educational, etc.)? _____ if yes, indicate when and the results: _____
4. Does your child receive any special services from the school (speech, language or reading tutoring, etc.)? _____ If yes, indicate the type and how often: _____
5. Is your child in a specialized classroom setting? (self-contained, resource, etc.)? _____ If yes, indicate the type: _____
6. What is the easiest subject at school for your child? _____ hardest subject? _____
7. What does your child report about school or school work? _____
9. Please check yes if you or your child's teacher noticed any of the following about your child:

____ Learns better if assignments are read aloud?
____ Tries to "sound out" words yet struggles with even simple words?
____ Spells words the way they sound rather than the way they are spelled?
____ Reversals when writing b/d, p/q?
____ Seems to quickly forget how to spell words just learned?
____ Does your child like school?
____ Does your child like his/her teacher?
____ Is the teacher satisfied with your child's performance?
____ Are you satisfied with your child's performance?
____ Is his/her school performance up to potential?
____ Is your child attending the grade level expected for his/her age?
____ Does your child read as well as others in the same grade or as well as brothers and sisters?
____ Does your child have at least average intelligence?

Please indicate any additional information that you believe may be helpful

_____

I hereby authorize Drs. Coulter, McRoy and Associates Eyecare to send a copy of the results of the evaluation on my child to:

Name _____ Address _____
Name _____ Address _____

Signed _____ Relationship _____