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

FOR PATIENT USE

Lifestyle Index

FOR OFFICE USE

PT INITIALS / ID _____

DATE _____

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — **whether it's caused by your eyes, posture, stress, etc.** Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? Fill in applicable circle. For example: 1 2 3 4 5 ○ ○ ● ○ ○

Headaches

- You get headaches of any severity each week (even just a dull ache counts).
- Your headaches tend to get worse later in the day.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Stiffness / pain in neck / shoulders

You experience stiffness/tension in your neck/shoulders when you work at a computer or read (this might even be from your posture).

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Discomfort with Computer Use

Your eyes get tired, burn, or get red easily when you work at a computer for long hours.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Number of hours per day using a digital device: _____

Tired Eyes

Your eyes feel increasingly fatigued/tired as the day goes on.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Dry Eye Sensation

Your eyes progressively feel more dry/sandy/gritty while working at the computer or reading.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Light Sensitivity

Bright / Strong lights (vehicle headlights, florescent lights etc.) bother you.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Dizziness

You experience dizziness, motion sickness, or vertigo.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Additional notes: _____

Additional Notes

Any additional notes you'd like to add: _____

_____

optos®

We pride ourselves on providing you with the best possible standard of care; because of this we offer the Optomap® Retinal Exam or Optos for short. The doctor prefers this quick, non-invasive image that allows her to see a much more detailed view of the retina, as opposed to traditional methods like dilating. This image becomes a permanent part of your medical file allowing the doctor to make comparisons year after 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 a more detailed retina view this will be discussed during your exam.

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

- Glaucoma
- Age related macular degeneration
- High blood pressure
- Diabetes
- Retinal holes or detachments
- Headaches
- Seeing spots or flashes
- High blood cholesterol
- Head trauma/concussion
- Histoplasmosis
- Birthmarks

The $29 fee for this procedure is a service that is not covered by insurance; therefore it is an out of pocket expense. Your doctor strongly believes that the Optos is an essential part of your comprehensive eye health exam and recommends all patients to have one. Any questions you have can be directed to your doctor during your examination.

( ) Yes: I would like to have the Optos performed ($29 fee)

OR

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

Patient Signature: _____ Date: _____