Welcome to Family EyeCare

Please take a moment to fill out this profile to help us meet your eye care needs. Insurance inquiries must be made prior to the examination.

Patient Information

Name (Last, First):____ Today's Date: ________________

Address: ____ Home Phone: ________________

City: ____________________ State: ___________ Zip: __________ Cell/Work #: __________________

Date of Birth: (M/D/Y)_________________________ Sex: M F Age: ________________________

Email: ____ Last Eye Exam Date: __________

Employer or School (if patient is a student) ____________________________ Grade: ______________________

Guardian (if applicable): ____ Occupation: _________________

NEW PATIENTS ONLY:

Who may we thank for referring you to our office? Name of friend or relative ____________________________

How did you hear about us?

□ Wal-Mart optical center □ Website/Internet listing □ Sign outside

□ Insurance provider list/book □ Patient/Friend_________ □ Other________________

Patient Eye History and Eyewear needs

Do your wear glasses? ☐ No ☐ Yes How old is your present pair of glasses?___________________________

Do you wear contact lenses? ☐No ☐ Yes if so, what brand? ________________ Replacement scheduled: ______

Are you satisfied with the vision and comfort of your contact lenses? ☐ No ☐ Yes

Would you prefer Color contact lenses? ☐ No ☐ Yes

Check any of the following that you may have had: ☐Crossed Eyes ☐ Lazy eye ☐Drooping eye lid ☐Glaucoma ☐Retinal Disease ☐Eye Infections ☐Eye Injury ☐Eye Surgery Date Occurred: ___________________________

Medical History

Do you have any allergies to medications? ☐No ☐Yes if yes, explain ______________________________________

____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies)

____

____

____

List all major injuries, surgeries and/or hospitalizations you may have had:

____

Are you currently: Pregnant ☐No ☐Yes Nursing: ☐No ☐ Yes

Social History -This information will be kept confidential. However you may discuss this portion directly with the doctor if you prefer.

Do you drink alcohol? ☐ No ☐ Yes Do you smoke? ☐ No ☐ Yes

Do you have a history of drug abuse? ☐ No ☐ Yes Do you drive? ☐ No ☐ Yes

--OVER--

Patient's Medical History/Review of Systems – Circle *Yes or No*	**Eyes (Ocular Symptoms) -** Circle *Yes or No*
N Y General: (Weight loss, Fever, Headache)	**N Y** Burning
N Y Ear/Nose/Throat: Hearing loss, Sinus Problems	**N Y** Blurry or Distorted Vision
N Y Heart: Chest pain, irregular heart beat	**N Y** Double Vision
N Y Respiratory: Short of breath, Wheezing, Asthma, Cough	**N Y** Excessive tearing/watering
N Y Digestive: Heartburn, Diarrhea, Reflux	**N Y** Eye pain or soreness
N Y Neurologic: Paralysis, Numbness	**N Y** Flashes/floaters in vision
N Y Skin: Rashes, Eczema	**N Y** Fluctuating visual acuity
N Y Psychiatric: Depression, Anxiety, Mental illness	**N Y** Itching
N Y Endocrine: Diabetes, Thyroid	**N Y** Loss of vision
N Y Cancer: Any type	**N Y** Loss of side vision
N Y Blood: Anemia, Sickle Cell, Excessive bleeding	**N Y** Mucus discharge
N Y Urinary: Kidney, Bladder issues	**N Y** Redness
Other: Please list ________________________________	**N Y** Sandy or gritty feeling

Self /Family History: Indicate **family** history (parents, grandparents, siblings, children; living or deceased) for the following conditions

Disease/Condition	**SELF**	**FAMILY**	**Relationship** <u>And</u> state Mother's or Father's side
Blindness	☐	☐	____________
Cataracts	☐	☐	____________
Glaucoma	☐	☐	____________
Macular Degeneration	☐	☐	____________
Retinal Problems	☐	☐	____________
Corneal Problems	☐	☐	____________
Eye Surgery	☐	☐	____________
Lazy Eye	☐	☐	____________
Diabetes	☐	☐	____________
High Blood Pressure	☐	☐	____________
High Cholesterol	☐	☐	____________
Heart Disease	☐	☐	____________
Thyroid	☐	☐	____________
Cancer	☐	☐	____________
Arthritis	☐	☐	____________
Lupus	☐	☐	____________
Other	☐	☐	____________

<u>DILATION</u> (Ask us if it's covered under your insurance) ***PLEASE READ CAREFULLY***

Dilation is the opening of the pupils by using medicated eye drops. This allows a better view of the retina and helps the doctor to detect many eye conditions that may be missed during a routine eye exam. **Dilation is strongly recommended for patients with a history cataracts, high blood pressure, high prescription, or older than 40 yrs. However, dilation is mandatory for patients with history of diabetic, glaucoma, and children under 12.** After dilation, you may experience increased light sensitivity, inability to focus up close, a slight blurring of your distance vision but you can see well to drive. These side effects last from 3-4 hours. We will provide a pair of disposable sunglasses for your comfort. ***The cost of this procedure is an additional $20.***

☐ **Yes, I do consent to having my eyes dilated.** ☐ **Yes,** but I would need to reschedule for another day.

☐ No, I do not want the dilation. By signing below, I understand and release **Dr. Nazia Maredia, O.D** and their doctors from all liability to treat or diagnose any eye condition due to lack of diagnostic information which could have been obtained from the dilation.

Please sign here if you DO NOT want the dilation. X ________________________________ Date: ______________

<u>VISUAL FIELDS TESTING</u>

A high-tech computerized device will be used to test your peripheral/side vision. This test helps to detect many types of visual field loss caused by eye diseases like glaucoma, brain tumor, retinal tear, or optic nerve defect, etc that cannot be detected with a comprehensive dilated exam. With early detection, this test can prevent many blindness-causing diseases before it is too late. *This test does not require eye drops.* ***The cost of this procedure is an additional $20.*** ☐ **Yes,** I would like to have it done today. ☐ No, I decline.

☐ ***Yes, I would like to have both tests done for a discounted price of $35***

By signing this form, I consent to treatment for myself or on behalf of the minor for which this information pertains. I give permission to the doctor(s) to examine, diagnose and treatment as appropriate. I further attest that I am the parent &/or legal guardian of the minor and can authorize treatment. **Patient/Guardian Signature:** ________________________________ **Date:** __________

I have read and understand the HIPPA Notice of Privacy Act (attached) ____________________ **(initials)**

For office use only: Doctor's Signature after reviewing the form: ____________________

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