Precision eye care & optical

Legal Name: _____ Date of Birth: ____-___-____ Date: ___-_____-___
(First) (Middle) (Last) (Nickname)

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip code)

Home Phone: _____ Work: _____ Cell Phone: _____

Email Address: _____@_____ Social Security #: _____-_____-_____

Communication Preference (Circle one) Telephone or E-mail

Preferred Language:_____ Race/Ethnicity: _____ Height: _____ Weight:_____

Do you smoke? _____ If yes, how much? _____ If Former, how long ago did you quit? _____

Marital status _____ Employer: _____ Occupation:_____

Driver License #: _____ Exp Date: _____ State: _____

List all Current medications including prescriptions, Over-the-counter, vitamins, or eye drops:

_____
_____

- I do **NOT** take any Medications
- I will **PRESENT** my medication list (That we could copy)

Are you allergic to any Medications? Yes_____ No_____ If yes, please list: _____
Do you wear contact Lenses? Yes_____ No_____ If yes, what type? _____
Are you interested in contact lenses? Yes_____ No_____

Do you have these on a ***regular basis*** Have **you** or a **family** member had any of the following?

Without glasses or contacts?

			You	**Family**	**(relation to you)**
Blurred Vision	___	Diabetes	____	_____	_____
Floaters in eyes	___	High Blood Pressure	____	_____	_____
Flashes of light	___	Cardiac Trouble	____	_____	_____
Burning Eyes	___	Breathing/Asthma	____	_____	_____
Itching Eyes	___	Cancer	____	_____	_____
Watery Eyes	___	Allergies	____	_____	_____
Dry Eye	___	Thyroid disorder	____	_____	_____
Eye Strain or pain	___	Macular Degen	____	_____	_____
Headaches	___	Glaucoma	____	_____	_____
		Lazy/crossed eye	____	_____	_____
Years since last eye exam _____		Cataracts	____	_____	_____

Last **Eye-** Doctor seen: _____ List any eye surgery you have had: _____
Primary Care Physician: _____

Parent/Guardian: _____
Birthday: _____-_____-_____
SSN: _____-_____-_____
Driver License #: _____

Have you turned to the back of this page to finished

The MOST important part of the eye examination

Eye Health Assessment: Thanks to advances in technology there are now TWO methods for evaluating the health inside your eyes. Please read carefully below:

Choice 1, Optomap: This is the NEWEST way to assess the retina! This high tech instrument scans the retina to help the doctor diagnose eye diseases such as macular degeneration, glaucoma, retinal detachments, diabetic bleeding, and even cancer. Benefits:

NO SIDE EFFECTS from the scan, so you won't be blurry or light sensitive!

SEE EXACTLY what the doctor sees. Using our large monitor, you'll get to see inside your own eye!

PERMANENT RECORD of the inside of your eye to reference on future visits.

QUICK & SIMPLE- takes only 2 to 3 minutes to complete.

Choice 2, Dilation: The traditional approach to look inside the eyes is dilation and is still available which adds an additional 20 minutes to the examination today. You'll be light sensitive and blurry at near for about 3 to 5 hours. Some people feel more comfortable having someone else drive afterward, and a few people get a mild headache. If someone has had a sudden onset of floaters and flashes or a recent head injury it is likely the doctor will dilate and scan the retina using the Optomap. *Sometimes dilation is required in order for the doctor to establish the proper glasses prescription or diagnosis.*

Dr. Duvall, Dr. Tade, and Dr. Baird highly recommend that you choose either Optomap or Dilation.

Please Check ONE option below:

Choice 1: ____ **Optomap**: I **Do** give permission to have the health of my eye checked using the Optomap scan.
(No blurry vision or light sensitivity, $29.00 fee due at end of appointment)

Choice 2: ____ **Dilation**: I **Do** give permission to have drops to check the health inside my eyes. (No charge)

Choice 3: ____ I want to **reschedule** dilation within 30 days. ($19.00 fee due at end of appointment)

Choice 4: ____ I do not want the health of my eyes checked using Optomap or dilation. (Not recommended)

Patient's Signature): _____ Date: _____
(or legal guardian IF younger than 18 yrs old)