Patient Visual Information

Name: ____ Date: ____/____/____

What is the primary reason for your visit today? ______________________________________

Date of last vision exam: ____/____/____ Doctor's Name: ______________________________

Do you wear glasses now? ❑Yes ❑No If yes, for what activities? ______________________

CONTACT LENS INFORMATION

Do you wear contact lenses? ❑Yes ❑No If yes, what type? ____________________________

How old are your contact lenses? __________ What lens care system do you use? ____________

Do you sleep in your lenses? ❑Yes ❑No If no, how many hours a day do you wear your lenses? ________

How often do you replace your contact lenses? ____________________

Are you interested in trying contact lenses? ❑Yes ❑No

Are you interested in corrective eye surgery? ❑Yes ❑No

Check if your eyes are bothering you in the following ways:

❑ Blurry vision at near	❑ Eye pain	❑ Dry eyes	❑ Red eyes
❑ Blurry vision at far	❑ Dizziness	❑ Itchy eyes	❑ Flaking Lids
❑ Change in vision	❑ Double vision	❑ Excessive tearing	❑ Floaters
❑ Contact lens problems	❑ Light sensitivity	❑ Discharge	❑ Headaches
	❑ Halos/spots	❑ Styes on lids	❑ Loss of sight

List any work activities or hobbies you participate in that may require special visual needs: ____________

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These additional tests are **NOT** covered by Vision Service Plan or Davis Vision

RETINAL PHOTOS

We can take pictures of the internal structure of your eyes to look for and document eye disease. In most cases this can be done in less than 10 minutes without dilating the eyes. This procedure also helps us detect subtle changes in your eyes over time which may sometimes go unnoticed. It will also help us determine the presence of retinal and optic nerve disease and monitor or detect glaucoma, diabetes, and many other problems. **The additional cost for this procedure is $18.00**

I would like to have these photos taken today. ❑Yes ❑No ____________ (Initial)

AUTOMATED VISUAL FIELD SCREENING maps out your vision, checking areas of lost sight in the central and peripheral visual fields. The objective of this more thorough test is to detect early signs of sight-threatening eye conditions such as: Glaucoma, Optic Nerve disorders, and Tumors of the visual pathway. Virtually all of the major causes of blindness in the United States can be detected by changes in your visual field. Therefore, we highly recommend this test for all our patients as part of their comprehensive exam. The test takes approximately 3 minutes per eye. **The professional fee for this additional service is $24.00.**

I would like to have an automated visual field test today. ❑Yes ❑No ____________ (Initial)

REVIEW OF SYMPTOMS AND FAMILY HISTORY

Please check off any applicable symptoms or problems; your optometrist will obtain additional details if necessary. If you have no problems in a specific area, please indicate by checking off the "None" box.

Patient ______________________ Primary Care Physician: ______________________

Date of last medical exam: __________ Are you pregnant? ☐ YES ☐ NO If yes, how many months? __________

List any known drug allergies: ☐ NONE ______________________

List any medications you are taking: ______________________

List any eye injuries, diseases or surgeries ______________________

		Briefly explain any checked.
☐ GENERAL Fever, night sweats, weight loss, fatigue	☐ None	
☐ EYE, EAR, NOSE, THROAT Sinus, otitis, hearing loss, ringing in ears, vertigo, allergies Glaucoma, Cataracts, Retinal disease, other	☐ None	
☐ CARDIOVASCULAR Heart attacks, cholesterol problems, congestive heart failure High blood pressure, heart murmurs, chest pains, arrhythmias	☐ None	
☐ RESPIRATORY Shortness of breath, asthma, wheezing, cough, emphysema, Chronic obstructive pulmonary disease	☐ None	
☐ GASTROINTESTINAL Colitis, ulcers, acid reflux, Crohn's disease, diarrhea	☐ None	
☐ KIDNEY, BLADDER, GENITALS Renal failure, dialysis, frequent urination	☐ None	
☐ MUSCLES, JOINTS, BONES Arthritis, joint pains, fractures, disc problems, other	☐ None	
☐ SKIN Skin cancers, rashes, itchiness, other	☐ None	
☐ NEUROLOGICAL Stroke, numbness, weakness, balance, gait, coordination, Speech, headaches, migraines, loss of consciousness, blind Spots in vision	☐ None	
☐ PSYCHIATRIC Anxiety, depression, insomnia, bipolar, other	☐ None	
☐ HORMONAL/ENDOCRINE Diabetes, thyroid problems, pituitary problems, other	☐ None	
☐ BLOOD/LYMPHATIC Bleeding problems, anemia, transfusions, blood loss, other	☐ None	
☐ INFECTIOUS DISEASES HIV, Hepatitis, Tuberculosis, other	☐ None	

FAMILY HISTORY

		Relationship
Glaucoma	☐ YES ☐ NO	________
Macular Degeneration	☐ YES ☐ NO	________
Retinal Detachment	☐ YES ☐ NO	________
Cataracts	☐ YES ☐ NO	________
Heart Disease	☐ YES ☐ NO	________
Diabetes	☐ YES ☐ NO	________
Cancer	☐ YES ☐ NO	________

SOCIAL HISTORY

Do you smoke? ☐ YES ☐ NO

Packs per day? ________

How many years have you smoked? ______

Do you drink alcohol? ☐ YES ☐ NO

How frequently do you drink? ________

Reviewed and discussed with patient ___/___/___ ______________________ O.D.

Reviewed and discussed with patient ___/___/___ ______________________ O.D.

Reviewed and discussed with patient ___/___/___ ______________________ O.D.