

Ophthalmology

Patient Name: _____ Today's Date: _____

Family Physician: _____ Date of last visit: _____

Last Eye Doctor: _____ Date of last visit: _____

How did you learn about our Clinic? _____

Eye History:

- 1. Do you wear glasses? Yes _____ No _____
- 2. Do you have problems reading with glasses? Yes _____ No _____
- 3. Do you wear contact lenses? Yes _____ No _____
 Type of contact lenses? Rigid _____ Soft _____ Extended wear _____
 Are they comfortable? Yes _____ No _____
- 4. Do you want to be fit for contact lenses for the first time? Yes _____ No _____
- 5. Do you want colored contact lenses? Yes _____ No _____

Family History:

- Glaucoma Yes _____ No _____
- Lazy Eye Yes _____ No _____
- Macular Degeneration Yes _____ No _____
- Hypertension Yes _____ No _____
- Diabetes Yes _____ No _____

Medical History:

- 1. Do you have any allergies to medications? Yes _____ No _____
 If yes, please list:

- 2. List any medications you take:

- 3. List all major injuries, surgeries, or hospitalizations you have had:

- 4. Have you ever had an eye injury or surgery? Please describe:

Social History

Occupation _____ Hobbies _____

If you are a student, name of school _____ What grade? _____

Do you smoke? Yes _____ No _____ If so, how much? _____

Do you smoke? Yes _____ No _____ If so, how much? _____

Review of Recent Symptoms:

Do you currently, or have you ever had any of the following:

- Constitutional (fever, weight loss/gain) Yes No
 - Integumentary (skin) Yes No
 - Neurological
 - Headache Yes No
 - Migraine Yes No
 - Seizures Yes No
 - Ears, Nose, Mouth, Throat
 - Allergies/Hayfever Yes No
 - Sinus Trouble Yes No
 - Chronic Cough Yes No
 - Dry Throat/ Mouth Yes No
 - Respiratory
 - Asthma Yes No
 - Chronic Bronchitis Yes No
 - Emphysema Yes No
 - Vascular/ Cardiovascular
 - Diabetes Yes No
 - Hypertension Yes No
 - Vascular Disease Yes No
 - Gastrointestinal
 - Diarrhea Yes No
 - Constipation Yes No
 - Genitourinary (genitals/kidney/bladder) Yes No
 - Bones/Joints/Muscular
 - Rheumatoid Arthritis Yes No
 - Muscle pain Yes No
 - Joint pain Yes No
 - Lymphatic/hematologic
 - Anemic Yes No
 - Bleeding disorder Yes No
 - Endocrine (thyroid, other glands) Yes No
 - Allergic/ Immunologic Yes No
 - Psychiatric (depression, anxiety, stress) Yes No
- Other health problems, Please List: _____

Dilated Eye Examination

By dilating the pupil of your eye, we can obtain a much more thorough view inside the eye. This assists us in detecting problems that may not be seen otherwise, such as cataracts, macular degeneration, diabetes, glaucoma, retinal detachments and others. There are some side effects to be aware of when having your eyes dilated. These include stinging upon instilling the drops and sensitivity to bright lights; we recommend wearing sunglasses after the exam for comfort. In most cases, you will be able to drive home afterward, but if you are at all uncomfortable with driving with your eye dilated, we can make arrangements for you to return for the dilation when you have someone with your to drive you home.

The purpose of this letter is to help you understand the benefits and disadvantages of dilation. Any further questions can be answered by the doctor.

_____ Yes, I consent to have my eyes dilated.

_____ Not today, I will reschedule.

_____ No, I do not consent to have my eyes dilated. I have read and understand the above benefits.

Patient Signature

Date

Urinary:

unusual fatigue yes/no
excessive thirst yes/no
swollen glands yes/no
weight change yes/no

Neurologic:

pain or burning yes/no
urinary frequency yes/no
penile discharge yes/no
blood in urine yes/no

muscle weakness yes/no
numbness/tingling yes/no
seizures/convulsions yes/no
loss of balance yes/no

Ears, Nose, Throat, Mouth:

hearing loss yes/no
bleeding gums yes/no
hoarseness yes/no
sore throat yes/no

Bones & Joints:

painful or stiff joints yes/no
swelling in joints yes/no

Gastrointestinal:

hard to swallow yes/no
abdominal pain yes/no
nausea/vomiting yes/no

Heart:

racing/fluttering yes/no
chest discomfort yes/no
swollen feet/ankles yes/no
shortness of breath yes/no

Lungs:

breathing difficulty yes/no
wheeze yes/no
cough yes/no
coughing up blood yes/no

Blood:

easy bruising yes/no
prolonged bleeding yes/no

Mood:

memory change yes/no
depression yes/no

Skin:

rash or hives yes/no
change in skin or moles yes/no

I have seen my internist/family physician for the above problems: Yes _____ No _____
address, also: _____

TO BE FILLED OUT BY THE NURSE:
