Eyeland Medical History Questionnaire

Name:_____ Date:_____

Date of Birth:_____ Age:_____ If Under 18, Parent / Guardian:_____

Address:_____City_____State:_____ Zip:_____

Phone:_____Email:_____Occupation:_____

Is this your first visit to our office? ____Yes ____No Date/Place of last eye exam:_____

What is the reason for your examination today?_____

List any medical conditions you are currently being treated for: _____

_____

List any medications you take: (including oral contraceptives, aspirin, over-the-counter meds or eye drops, vitamins and home remedies)

_____

_____

Do you have any allergies to medications? ___Yes ___No If Yes, list:_____

Check any of the following conditions that you currently have, or have previously had:

___Inflammatory Disorder ___Diabetes ___High Blood Pressure ___Thyroid Disease ___Cancer ___Cataract

___Crossed Eye ___Keratoconus ___Lazy Eye ___Glaucoma Suspect ___Glaucoma ___Eye Surgery

___Retinal Degeneration/Hole/Detachment ___Eye Patching ___Eye Injury ___Macular Degeneration

Are you currently pregnant or nursing? _____Yes _____No

Do you wear glasses? ___Yes ___No If Yes, how old is your current pair of lenses?_____

Do you wear contact lenses? ___Yes ___No If Yes, what brand?_____ ___Soft ___Hard

Are you interested in contact lenses today? (There is an additional charge for a contact lens exam) ___Yes ___No
(This charge may or may not be covered by your insurance, If you are uncertain, be sure to ask our staff BEFORE your examination)

Family History:
Please check any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

___Thyroid Disease ___Diabetes ___Glaucoma ___High Blood Pressure ___Cancer ___Crossed Eyes

___Glaucoma Suspect ___Cataract ___Lazy Eye ___Severe Nearsightedness ___Macular Degeneration

___Severe Farsightedness ___Retinal Detachment/Disease Other:_____

Social History: This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? ___Yes ___No If Yes, do you have visual difficulty when driving / glare at nighttime? ___Yes___No

Do you use tobacco products? ___Yes ___No If Yes, type/amount/how long?_____

Are You A: ____Former Smoker ____Current Occasional Smoker ____Current Everyday Smoker

Do you drink alcohol? ____Yes ____No If Yes, type/amount/how long?_____

Do you use illegal drugs? ____Yes ____No If Yes, type/amount/how long?_____

Reviewed by: (Doctor)_____

IMPORTANT: INSURANCE INFORMATION ON REVERSE SIDE

This box for office use only

Patient Name: _____ Date: ___/___/___

Previous Rx GL: Previous Rx CL:

_____ _____

_____ _____

I acknowledge that I have read and received Eyeland Optical's Notice of Privacy Practices for protected health information.

Signature:_____ Date:_____

Dilated Eye Examination: Dilation is a medical procedure, which allows the doctor to use eye drops to temporarily enlarge your pupils for a more extensive view of the retina (back of the eye). With dilation, the doctor has the opportunity to evaluate and diagnose eye health problems before symptoms occur. It is recommended that all new patients are dilated, and again every 2 to 4 years thereafter, unless certain conditions require closer monitoring. SOME PATIENTS MAY EXPERIENCE LIGHT SENSITIVITY AND BLURRED VISION FOR 2 TO 6 HOURS, OR LONGER. If you do not have dark sunglasses for your travel home, we will provide you with a disposable pair. You may have difficulty driving after the procedure, if you feel more comfortable being driven, please make arrangements to do so. In rare instances, patients may experience pain or other side effects. If this should occur, please seek medical attention immediately. Please advise our doctor if you are pregnant or nursing at this time. If you have any other health conditions that may effect your response to these tests or questions regarding dilation, please consult our doctor for additional information. Please sign your initials on the space provided to indicate that you have read and understand the above.

Do you wish to have your eyes dilated? ___Yes ___No Initials:_____ Reviewed by: (Doctor)_____

INSURANCE INFORMATION

Do you have VISION insurance? ____Yes ____No If Yes, insurance carrier:_____

Subscriber (Primary Insured) Name:_____ Subscriber DOB:_____

ID#:_____ Employer Who Issues Coverage:_____

Do you have MEDICAL insurance? ____Yes ____No If Yes, insurance carrier:_____

Subscriber (Primary Insured) Name:_____ Subscriber DOB:_____

ID#:_____ Employer Who Issues Coverage:_____

Do you have Medicare? ____Yes ____No If Yes, ID number: _____

Leave Blank: Office Staff to photocopy insurance cards in space below: