

Today's Date: _____

WELCOME TO EYE TO EYE, P.A.

Mr. Mrs. _____

Ms. Dr. Patient's Last Name First Name Middle Name

Street Address City State Zip Code

Home Phone Business Phone Cell Phone Date of Birth Age

Email Address Employer /Occupation Hobbies

Last, First Name of Primary Member for Insurance His/Her Date of Birth His/Her SS# His/Her Health card ID #

Patient's Gender: Male Female How did you hear about us? _____

Reason for Today's Visit

Eye injury from _____ on date _____
Circle symptoms you have: Blurry vision / Redness / Pain / Sensitivity to light / Tearing / Swelling / Floaters / Flashes of light

Bump on lid since date _____
Circle symptoms you have: Blurry vision / Redness / Pain / Sensitivity to light / Tearing / Swelling

Other _____
Circle symptoms you have: Blurry vision / Redness / Pain / Sensitivity to light / Tearing / Swelling / Floaters / Flashes of light

Patient Ocular History: (Check all that apply.)

___ Dry eyes ___ Eye injury, which eye? R or L
___ Itchy eyes explain _____
___ Burning of eyes ___ Eye surgery, which eye? R or L
___ Tearing of eyes explain _____
___ Double vision ___ Lazy eye, which eye? R or L
___ Cataracts ___ Eye turn, which eye? R or L
___ Retinal disease ___ Retinal detachment, which eye? R or L
___ Flashes of light ___ Glaucoma, when diagnosed? _____
___ Floaters/spots meds used _____

Date of last eye exam: _____

What was the outcome of the exam?

Glasses Contacts Treatment with eye drops

Interest:

I would like to know my contact lens options.
 I would like to know about refractive surgery options.

General Health History: (Check all that apply.)

	Patient	Family	Year diagnosed or more info
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery	_____	_____	_____
Other	_____	_____	_____

Medications: _____

Last physical exam: _____
Allergies to medications? Yes / No (If yes, _____)

Allergies: _____

If applicable:

Do you smoke? Yes / No (If yes, how many packs/day? _____)

Are you pregnant? Yes / No (If yes, how many months? _____)

Family Ocular History: ___ Glaucoma ___ Retinal disease ___ Retinal detachment ___ Other _____

Explain: _____

PUPIL DILATION (TO CHECK THE HEALTH OF YOUR EYES)

Dilation may be necessary, especially with an eye injury. It takes about 30 minutes, can cause blurry reading or near vision, and cause a sensitivity to light for several hours; however, most patients can drive home after the dilation. There is not an additional cost.

My signature below indicates: 1. I have been informed of my rights under the HIPAA Privacy Policies. 2. As a potential contact lens wearer, I have read and understood the Contact Lens Guide, and I have been informed that potential risks, although rare, do exist in wearing contact lenses. 3. I understand that all fees paid for professional services are non-refundable and are payable at the time of service. 4. I accept the policies regarding the purchase of spectacle lenses, frames, or contact lenses.

Patient's signature Date

Legal guardian (if patient is under 18) Date