Patient History

Do you or anyone in your immediate family have a history of the following?

	Self	Blood Relative		Self	Blood Relative
Cataracts	**O**	**O**	Diabetes	**O**	**O**
Glaucoma	**O**	**O**	High blood pressure	**O**	**O**
Retinal disease	**O**	**O**	High cholesterol	**O**	**O**
Crossed eyes	**O**	**O**	Heart disease	**O**	**O**
Blindness	**O**	**O**	Thyroid disease	**O**	**O**

Are you allergic to any medications? (Y / N) If so, please indicate? _____

List all medications you are taking _____

Are you pregnant? (Y / N) Do you smoke / drink / use recreational drugs (circle)

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

☐ Eye surgery ☐ Eye injury ☐ Eye infection ☐ Floaters or spots

☐ Sensitivity to light ☐ Double vision ☐ Distance blur ☐ Near blur

☐ Eye strain ☐ Eye burn, itch or water ☐ Severe pain

Do you currently wear glasses? (Y / N) Age of glasses _____

Have you ever worn contacts? (Y / N) Are you interested in contacts today? (Y / N)

Do you use a computer? (Y / N) How many hours per day? _____

What hobbies or sports do you participate in? _____

Dilated Eye Examination Information

Dilated eye exams are important to allow the doctor a better view of the retina. All patients should have their eyes dilated on a yearly basis, especially those experiencing a recent onset of flashes of light or floaters, those with a history of diabetes, high blood pressure, or heart disease and patients with a high vision prescription.

You should expect the following side effects from the dilation:

1. Sensitivity to sunlight
2. Blurry vision for a period of 4 to 6 hours, particularly up close; driving is not recommended following the dilation exam.

( ) I would like my eyes dilated, if required **( )** I would like to schedule an appointment for dilation **( )** I decline dilation

I certify I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X_____ _____

Signature of patient (or parent if a minor) Date