

WELCOME TO OPTIQUE! Patient Information

Name: _____ Date of Appointment: _____
Parent/Guardian Name: _____ Date of Birth: _____
Address: _____ Occupation: _____
City, State, Zip: _____ Hobbies/Sports: _____
Phone: _____
Date of Last eye exam: _____ Where: _____

What are the main reasons for your appointment today? (Please check all that apply)

- () Annual Eye Exam () Matter/Mucus in Eyes () Seeing Flashes of Light
() Contact Lens Exam () Dry Eyes () Floating Spots in Vision
() Near Blurred Vision () Red Eyes () Double Vision
() Distance Blurred Vision () Burning Eyes () Foreign Material in Eyes
() Frequent Eyestrain () Watery Eyes () Eye Pain
() Frequent Headaches () Itchy Eyes () Contact Lens Discomfort
() Other _____

Check any medical conditions that apply to you

- () Diabetes () Asthma () Stroke
() High Blood Pressure () Lung Disease () Heart Disease
() Thyroid Disease () Arthritis () High Cholesterol
() Cancer () Seizures () Other _____

Physician's Name _____ Date of Last Medical Exam _____

Check any eye conditions that apply to you

- () Glaucoma () Eye Injury; Describe _____
() Cataracts () Eye Surgery; Describe _____
() Macular Degeneration () Other; Describe _____
() Turned Eyes

Check any conditions that are present in your family members

- () Glaucoma () Diabetes () High Blood Pressure
() Cataracts () Turned Eyes () Loss of Vision/Blindness
() Macular Degeneration

Tobacco use () YES or () NO; If Yes, what type? _____ Amount? _____

Alcohol use () YES or () NO; If Yes, Frequency? _____ Amount? _____

Current Medications (including vitamins): _____

Allergies to Medications: _____

Other Allergies (pollen, dander, etc.): _____

Eye Drops Used (either daily or occasionally): _____

Are you pregnant or nursing? () YES or () NO

Contact Lens History:

- () I am interested in contact lenses or would like to know more about them.
() I have worn contact lenses in the past and would like to try them again.
() I currently wear contact lenses.

What type? _____

How long have you had this pair? _____

Any problems with your current contacts? _____

DILATION: Dilation allows the Doctor to thoroughly examine the inside of your eyes for signs of disease or potential problems which may otherwise go undetected. Dilation usually wears off in 3-4 hours. You will have blurry near vision and sensitivity to bright lights during this time. Most people see well at distance with their glasses and are able to drive following dilation. If you are dilated and do not feel comfortable driving, we will assist you in making transportation arrangements.

() YES: I understand the importance of dilation and its side effects, I grant permission to dilate.

Signed: _____

() NO: I understand the importance of dilation, however, I DO NOT want to have my eyes dilated. Signed: _____