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	**( ) Watering 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:_____