Last Name: ______________________

First Name: ______________________ Nickname: ______________________

Street Address: ______________________

City: ______________________ State: ______________ Zip Code: __________

Home Phone: ______________________ Daytime Phone (if different): ______________________

Cell Phone: ______________________ May we text you: ❑ Y ❑ N

E-Mail Address: ______________________

Referred By: ______________________

Sex: ❑ M ❑ F Date of Birth: ______________ Social Security Number: ______________

Marital Status: ______________________ Employment Status: ______________________

Employer: ______________________ Occupation: ______________________

Race:
- Native American/Native Alaskan ❑
- Asian ❑
- Black/African American ❑
- Hispanic ❑
- Native Hawaiian/Other Pacific Island ❑
- White ❑

Do you currently wear contacts? ❑ Y ❑ N If yes:
What time of day do you start to feel them on your eyes? ________
Do you ever use lubricating drops? ❑ Y ❑ N
Do you desire an improvement in comfort and/or vision? ❑ Y ❑ N
If no:
Would you like to wear contacts? ❑ Y ❑ N
Have you worn them in the past? ❑ Y ❑ N
If so: Why did you stop? ______________________
Are you interested in LASIK? ❑ Y ❑ N

Last Eye Exam: ______________________ Doctor: ______________________

PATIENT HEALTH HISTORY

Primary Care Physician ______________________ Date Last Seen: ______________________

Medical/Family History (use additional sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy): ______________________

____

____

List all major surgeries in the last five years (Eye Surgery included): ______________________

____

List any allergic reactions to medications, eye drops or food: ______________________

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease Condition	**Yourself** *Yes*	*No*		**Family Member** *Yes*	*No*	**Relationship (blood relatives only)**
Cataract	❑	❑	Blindness	❑	❑	________
Eye Turn	❑	❑	Eye Turn	❑	❑	________
Glaucoma	❑	❑	Glaucoma	❑	❑	________
Macular Degeneration	❑	❑	Macular Degeneration	❑	❑	________
Retinal Detachment	❑	❑	Retinal Detachment	❑	❑	________
Other:						

Women: Are you pregnant? ❑ Yes ❑ No Are you breast feeding? ❑ Yes ❑ No

PATIENT HEALTH HISTORY (Cont'd.)

Review of Systems: Please Indicate Below if you have or ever had problems with the following conditions:

Allergic/Immunologic
❑ None
❑ Lupus (SLE)
❑ Rheumatoid Arthritis
❑ Environmental Allergies
❑ Seasonal Allergies
❑ Other (i.e., Latex)

Ear, Nose and Throat
❑ None
❑ Sinusitis
❑ Upper Respiratory Tract Infection
❑ Other

Gastrointestinal
❑ None
❑ Crohn's Disease
❑ Colitis
❑ Acid Reflux/Ulcer
❑ Other

Skin/Integumentary
❑ None
❑ Eczema
❑ Rosacea
❑ Psoriasis
❑ Other

Psychiatric
❑ None
❑ Depression
❑ Bi-Polar
❑ Schizophrenia
❑ Other

Cardiovascular
❑ None
❑ High Blood Pressure
❑ Heart Disease
❑ Stroke
❑ Vascular Disease
❑ High Blood Cholesterol

Endocrine/Glands
❑ None
❑ Diabetes
❑ Hormone Dysfunction
❑ Thyroid Dysfunction
❑ Other

Respiratory
❑ None
❑ Asthma
❑ Bronchitis
❑ Emphysema
❑ Other

Muscle/Skeletal
❑ None
❑ Arthritis
❑ Fibromyalgia
❑ Ankylosing Spondylitis
❑ Other

Genital/Urinary
❑ None
❑ Urinary Tract Infection
❑ HIV Positive
❑ Herpes/Chlamydia
❑ Other

Hematologic/Lymphatic
❑ None
❑ Anemia
❑ Leukemia
❑ Bleeding Disorder
❑ Other

Neurological
❑ None
❑ Multiple Sclerosis
❑ Epilepsy
❑ Tremors
❑ Other

General Health
❑ None
❑ Weight Loss/Gain
❑ Fever
❑ Fatigue
❑ Trauma

Social
Tobacco Use:
❑ Current Smoker ❑ Former Smoker
❑ Non-Prescription______________________________
❑ Alcohol Consumption_________________________

** PUPIL DILATION - YOU MUST ANSWER THIS SECTION **

Dilation of the pupil is considered standard procedure as part of a comprehensive eye examination. Dilating drops enlarge the size of the pupil and allow the doctor a more thorough examination of the retina. Dilation assists in detection of glaucoma, cataracts, diabetic and hypertensive retinal changes, retinal degenerative changes, retinal holes, retinal tears and detachment and some types of tumors. Side effects include light sensitivity and trouble focusing up close.

Pupil Dilation: ❑ Yes ❑ No Signature:____

EYECON VS. DILATION

No drops, no waiting for drops to take effect, no blurred vision for hours and no light sensitivity.

The doctors at Today's Vision are concerned about retinal problems. These problems may include *macular degeneration, glaucoma, retinal holes, retinal detachments and retinal diseases*, such as *diabetic retinopathy* and ocular tumors. These conditions *may* lead to partial loss of vision or complete blindness.

EARLY DETECTION IS CRUCIAL

The EyeCon provides:

- A non-invasive, detailed, in-depth view of the retinal layers (where disease may begin).
- The ability to immediately show you and educate you about the health in the back portion of your eyes.
- A permanent record of your inner eye health (important for year to year comparisons for diagnosing and tracking eye diseases).
- A digital computerized map of the retina.

Because your insurance is designed to cover only a basic exam, it currently ***does not cover*** *advanced technology screening tools such as the EyeCon.* **$39.00**

_____I consent _____I decline to having an EyeCon exam.

Patient/Guardian Signature: ____ Date: _______________

NOTICE OF PRIVACY PRACTICES

_____I acknowledge that I have read a copy of the Today's Vision Notice of Privacy Practices
_____I consent to the policies contained in the Today's Vision Notice of Privacy practices.

Signature:____ Date: _______________