Patient Name: _____ DOB: _____ Date: _____

Reason for today's exam _____

Medications currently taking: _____

Please update address or phone numbers: _____

Do you or anyone in your immediate family have a history of the following: (please circle)

Systemic Diseases:	**Yourself**		**Family**	
Diabetes	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Thyroid	Yes	No	Yes	No
Elevated Cholesterol	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No
Heart Condition	Yes	No	Yes	No

Eye Related Diseases	**Yourself**		**Family**	
Cataracts	Yes	No	Yes	No
Glaucoma	Yes	No	Yes	No
Macular Degeneration	Yes	No	Yes	No
Elevated Eye Pressure	Yes	No	Yes	No
Flashing Lights	Yes	No	Yes	No
Floaters	Yes	No	Yes	No
Lazy Eye / Eye Turn	Yes	No	Yes	No
Dry Eye Syndome	Yes	No	Yes	No
Eye Surgery	Yes	No	_____	

General Questions:

Do you feel your vision has changed? Yes No

How long has it been since your last vision exam? _____

Are you a new patient to this office? Yes No

*** If you answered YES to any questions above or if it's been more than 2 years since your last dilated/extended health exam, we strongly urge you to schedule these important health tests.***

EXTENDED TESTING INCLUDES:

Dilation: This requires eye drops that will allow the doctor to look in the back of your eye and ocular diseases.

Visual Field Testing: This determines any defects in your central and peripheral vision that may be caused by certain diseases such as glaucoma, cataracts and macular degeneration.

Retinal Topography / HRT: This test evaluates the optic nerve and retina which may be affected by the some systemic diseases.

Which time of day would be best suited for your extended testing?

Morning **Afternoon** **Evening**