



WELCOME! PLEASE HELP US EXPEDITE YOUR VISIT BY FILLING OUT THIS FORM. YOU CANNOT BE SEEN UNTIL EVERY QUESTION HAS BEEN ANSWERED. THANK YOU!

PERSONAL DATA

Today's Date: \_\_\_\_\_ Title: Mr. Mrs. Ms. Dr. Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_
Name: \_\_\_\_\_ Male Female
Last Name First Name Middle Name

MEDICAL AND SURGICAL HISTORY

Family Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_
Family Physician's Address: \_\_\_\_\_

Eye History - Please check all the conditions that apply to you

YES NO

- Wear glasses for distance (e.g. TV, driving)
  Wear glasses for reading
  Wear contacts, if YES circle HARD SOFT
  Cataracts
  Glaucoma
  Drooping Eyelids

YES NO

- Retinal Disease
  Crossed Eyes
  Lazy Eyes
  Eye Injury
  Have you had cataract surgery?
  Dry Eye Disease

Do you have any other eye diseases? \_\_\_\_\_
Have you had any other eye surgeries? \_\_\_\_\_

Medical History - Please check all the conditions that apply to you

YES NO

- Diabetes
  Hypertension
  Heart Attack

YES NO

- Emphysema
  Depression
  Stroke

Do you have any other diseases? \_\_\_\_\_
Have you had any other surgeries? \_\_\_\_\_

List any medications you take (including over-the-counter medications and home remedies): \_\_\_\_\_

Do you have drug allergies? Yes No If yes, please list: \_\_\_\_\_

SOCIAL HISTORY

Do you smoke? Yes No If yes, type/amount/how long: \_\_\_\_\_
Do you drink alcohol? Yes No If yes, type/amount/how long: \_\_\_\_\_
Do you use illegal drugs? Yes No If yes, type/amount/how long: \_\_\_\_\_

FAMILY HISTORY

Does anyone in your family have:

YES NO

- Diabetes
  Glaucoma
  Macular Degeneration

RELATIONSHIP

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YES NO

- Strabismus (Crossed Eyes)
  Amblyopia (Lazy Eye)
  Other \_\_\_\_\_

RELATIONSHIP

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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**REVIEW OF SYSTEMS**

Please indicate if you are experiencing problems in the following areas:

	YES	NO		YES	NO		YES	NO
<b>CONSTITUTIONAL</b>			<b>EYES</b>			<b>CARDIOVASCULAR</b>		
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
<b>INTEGUMENTARY</b>			Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<b>GASTROINTESTINAL</b>		
<b>NEUROLOGICAL</b>			Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Mucus Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESPIRATORY</b>			Redness	<input type="checkbox"/>	<input type="checkbox"/>	<b>GENITOURINARY</b>		
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<b>MUSCULOSKELETAL</b>		
<b>EAR/NOSE/MOUTH/THROAT</b>			Burning	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Tearing	<input type="checkbox"/>	<input type="checkbox"/>	<b>HEMATOLOGIC/LYMPHATIC</b>		
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Post-nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<b>ALLERGIES/IMMUNOLOGICAL</b>		
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	<input type="checkbox"/>
<b>ENDOCRINE</b>			Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<b>PSYCHIATRIC</b>		
Thyroid/Other Gland	<input type="checkbox"/>	<input type="checkbox"/>	Infection of Eye or Eyelid	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**REASON FOR YOUR VISIT TODAY**

\_\_\_\_\_  
 \_\_\_\_\_

**LASER VISION CORRECTION (LASIK)**

Yes No Would you like to discuss laser vision correction (LASIK) to reduce your need for eyeglasses and/or contact lenses?.

**NUTRITIONAL SUPPLEMENTS & VITAMINS**

Yes No Would you like to discuss what nutritional supplements & vitamins are important for maintaining the health of the body and eyes?

**NOTICE OF PRIVACY RIGHTS AND PRACTICE**

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), we are required to make every effort to inform you of your rights related to your personal health information. By signing below, you acknowledge that you have read or declined to read Sugarland Eye & Laser Center's Notice of Privacy Practices, a copy of which is available in the office.

\_\_\_\_\_  
 Your Signature

\_\_\_\_\_  
 Date



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**PRESCRIPTION FOR EYEGLASSES**

The purpose of a medical evaluation is to comprehensively evaluate the medical/surgical health of the eyes. This evaluation includes dilation and, in some cases, additional testing. Refraction, which is measuring the eyes for eyeglasses, is **NOT** part of this evaluation as defined by your health insurance policy. **The fee for this service is \$50 and is not refundable as refractions do fluctuate based on medical conditions and patient performance. This fee includes recheck within 60 days only. A fee will be charged for rechecks after 60 days.** Please check below whether or not you would like a refraction.

Yes No Would you like a refraction (measuring the eyes for eyeglasses)?

**PRESCRIPTIONS FOR CONTACT LENSES**

Your glasses prescription is not the same as your contact lens prescription. A contact lens fitting includes measuring the eyes for healthy and comfortable contact lenses. The prescription cannot be finalized until the eyes are evaluated while wearing a pair of trial lenses. Trial lenses may need to be ordered. Several visits may be necessary to complete a proper contact lens fitting. **Separate fees apply for contact lens fitting and for shipping & handling. Insurance does NOT fully cover your contact lens fitting, related shipping & handling charges, and your supply of contact lenses. Some plans require for you to purchase contact lenses from the same provider that performed the contact lens fitting, otherwise you may be fully responsible for all contact lens fitting fees. Additional fees will apply for contact lens checks more than 30 days after dispensing of trials.**

Yes No Would you like a prescription for contact lenses? Please consult the front desk for our current fees.

**WARNING REGARDING DILATION**

The pupil is the black circle in the middle of the eye. The pupil gets larger in dark lighting conditions and smaller in bright lighting conditions. During your medical examination(s), we will put drops in you eyes to temporarily enlarge the pupil allowing the doctor to examine the inside of your eyes. This process is called *dilation*.

Dilation carries a very small risk of precipitating an attack of a disease called angle closure glaucoma. The risk of this is estimated to be less than 1 in 45,000 (0.002%) in people over age 30. Consequently, the risk of not detecting a serious eye condition by failing to dilate the eyes is much greater than that of precipitating glaucoma. Sugarland Eye & Laser Center has procedures in place in the event that angle closure glaucoma does occurs.

You will have to wait at least 30 minutes after dilation drops have been applied in order for the drops to work. The drops will mostly blur your near vision and make things much brighter. Sunglasses can be provided to you. The effects of the drops will last 4 to 6 hours, though individual variations do occur. Following dilation, it will be more difficult to drive. Most individuals are able to drive home slowly in good driving conditions along familiar paths. However, some individuals will have to avoid driving for several hours due to visual disturbances. **If your vision is significantly disturbed following dilation, driving a car and/or a motorbike should be avoided.**

Yes No Would you like your eyes to be dilated? Checking one of these boxes confirms that you have read and understood the risks and benefits of dilation and of refusing dilation.

**PLEASE SIGN BELOW**

By signing below, you certify that you have read this entire form in its entirety, and both understand and accept all terms and conditions as they are written. Furthermore, all information you have provided in this form is true and accurate to the best of your knowledge.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date