



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
CONSTITUTIONAL			EYES			CARDIOVASCULAR		
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"/>
INTEGUMENTARY			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"/>	GASTROINTESTINAL		
NEUROLOGICAL			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"/>
RESPIRATORY			Redness	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY		
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"/>	MUSCULOSKELETAL		
EAR/NOSE/MOUTH/THROAT			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"/>	HEMATOLOGIC/LYMPHATIC		
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"/>	ALLERGIES/IMMUNOLOGICAL		
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE			Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC		
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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PLEASE READ THE FOLLOWING SECTION CAREFULLY

The purpose of a routine eye examination is to address blurry vision due to the need for glasses. A prescription for eyeglasses is provided if needed. Rechecking of your glasses prescription will be complimentary for 1 month only when needed. The doctor may detect medical/surgical issues during this examination. A routine eye examination does **NOT** include evaluation for any medical/surgical reasons such as red eyes, itchy eyes, dry eyes, diabetes, high blood pressure, cataract, glaucoma or family history of glaucoma, eye injury, bulging of eyes, crossing of eyes, difference in the size of the eyes, dimming of vision that comes and goes, sudden loss of vision, discharge, crusting, excessive tearing, double vision, eye pain, flashes or streaks of light, foreign body sensation, haloes, headaches, loss of side vision, floaters, swelling of any part of the eye, twitching or shaking of the eye, blurry vision uncorrectable by glasses or contact lenses, etc. Any medical / surgical issues will have to be addressed at a separate visit.

By signing this form, you understand that a routine eye examination will NOT address any medical/surgical issues. In the event that a medical/surgical issue preexists or is newly noted during the course of your routine eye examination, you understand that further evaluation and treatment can only be performed by scheduling a medical eye examination on a separate day. Sugarland Eye & Laser Center recommends all individuals to have a medical eye evaluation at least once a year and we would be happy to assist you in scheduling one.

Yes No Would you like to schedule a medical eye evaluation at the end of today's visit?

DILATION

You may elect to have certain eye drops placed in you eyes to temporarily enlarge your pupils allowing the doctor to screen for any medical/surgical issues in the back of your eyes. This process is called *dilation* and carries a 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. 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 blur your near vision and make things much brighter. 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. **If your vision is significantly disturbed following dilation, driving a car and/or a motorbike should be avoided. The fee for this service is \$65 and is often NOT covered by your benefit plan.**

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.

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.

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