Burnt Hills Optical

Last Name________________________ First Name____________________ MI____ Date of Birth: __________

Family History

Is there any family medical history of any of the following? (**If yes please list the relationship to you**)

Cataracts	□Yes □No	_______________	Diabetes	□Yes □No	___________________
Glaucoma	□Yes □No	_______________	High Blood Pressure	□Yes □No	___________________
Lazy Eye	□Yes □No	_______________	Retinal Detachment	□Yes □No	___________________
Macular Degeneration	□Yes □No	_______________	Color Blindness or other	□Yes □No	___________________

Patient Eye History

Have you ever been diagnosed or treated for the following?

Cataracts	□ Yes □ No
Glaucoma	□ Yes □ No
Macular Degeneration	□ Yes □ No
Retinal Detachment	□ Yes □ No
Lazy eye or Eye turn	□ Yes □ No
Eye Injury	□ Yes □ No
Eye Surgery	□ Yes □ No
Blurry Vision	□ Yes □ No

Do you experience any of the following?

Headaches	□ Yes	□ No	□ Sometimes
Double Vision	□ Yes	□ No	□ Sometimes
Persistent Floaters	□ Yes	□ No	□ Sometimes
Flashes of Light	□ Yes	□ No	□ Sometimes
Eye Itching	□ Yes	□ No	□ Sometimes
Eye Tearing	□ Yes	□ No	□ Sometimes
Eye Burning	□ Yes	□ No	□ Sometimes

Other: ______________________________________

Have you ever been diagnosed or treated for any of the following conditions?		**Explanation of Condition**
Endocrine- thyroid, hormones, glands	□ Yes □ No	____
Cardiovascular – heart, blood vessels	□ Yes □ No	____
High Blood Pressure	□ Yes □ No	____
Respiratory- lungs, breathing	□ Yes □ No	____
Gastrointestinal- stomach/ intestines	□ Yes □ No	____
Genitourinary- genitals, kidneys, bladder	□ Yes □ No	____
Musculoskeletal- muscles, joints, arthritis	□ Yes □ No	____
Skin or other Integument Condition	□ Yes □ No	____
Neurological- migraine, seizures	□ Yes □ No	____
Psychiatric	□ Yes □ No	____
Ears, Nose, Mouth or Throat	□ Yes □ No	____
Hematologic/Lymphatic- anemia, bleeding	□ Yes □ No	____
Allergic/ Immunologic	□ Yes □ No	____
HIV/AIDS	□ Yes □ No	____
Cancer	□ Yes □ No	____

Do you have Diabetes? □Yes □No What year were you diagnosed? ___Type 1□ or 2□ What was your last HbA1c? _______
Do you drink alcoholic beverages? □ Yes □ No □ Sometimes
Are you currently Pregnant or Nursing? □ Yes □ No

Authorization to pay benefits to physician.

I hereby authorize payment of benefits directly to the doctor for services received. I understand that I am responsible for the balance of fees not paid by the insurance.

Please sign below that you have reviewed all of the information above and it is correct to the best of your knowledge.

Signature____ ***Date***___________________________

Please bring a list of all your current medications to your appointment

Last Name________________________________ First Name________________________________ MI_______

Your Vision Lifestyle

Please check how often you currently wear the following forms of sight correction and/or sight protection.

Glasses	□ Always	□ Often	□ Sometimes	□ Never
Contact lenses	□ Always	□ Often	□ Sometimes	□ Never
Non Prescription Sunglasses	□ Always	□ Often	□ Sometimes	□ Never
Prescription Sunglasses	□ Always	□ Often	□ Sometimes	□ Never
Safety or Sport Eyewear	□ Always	□ Often	□ Sometimes	□ Never

Please check your participation level in the following activities and indicate whether or not use your glasses/contact lenses for that activity.

			I Use eyewear for this activity:	
Reading	□ Frequently	□ Infrequently	□ Yes	□ No
Computer Use	□ Frequently	□ Infrequently	□ Yes	□ No
Television	□ Frequently	□ Infrequently	□ Yes	□ No
Driving	□ Frequently	□ Infrequently	□ Yes	□ No
Sports (please specify____________)	□ Frequently	□ Infrequently	□ Yes	□ No
Other: ________________________	□ Frequently	□ Infrequently	□ Yes	□ No

Do you currently experience any of the following problems with your current eyewear?

Too Heavy	□ Always	□ Often	□ Sometimes	□ Never
Poor fit or wrong size	□ Always	□ Often	□ Sometimes	□ Never
Difficulty with bifocal	□ Always	□ Often	□ Sometimes	□ Never
Too much glare	□ Always	□ Often	□ Sometimes	□ Never
Need for constant adjustment	□ Always	□ Often	□ Sometimes	□ Never

Do You:

Spend a lot of time outdoors	□ Yes	□ No
Currently have prescription sunwear	□ Yes	□ No
Want information on laser vision correction	□ Yes	□ No
Currently have computer eyewear	□ Yes	□ No
Wear bifocals	□ Yes	□ No
Think you would benefit from thinner, lighter lenses	□ Yes	□ No
Have an interest in "no line" bifocals/progressive lens	□ Yes	□ No
Have an interest in transitions/photochromatic lenses	□ Yes	□ No
Have an interest in being fit for contact lenses	□ Yes	□ No

Do you have any other visual needs you would like us to address? □ Yes □ No

If so, please explain:

____

____

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Wellness Package

We strive to provide the newest technology and best medical eye care possible. We proudly offer digital retinal imaging technology and visual field screening to assist in retinal examination.

As a non-invasive and instantaneous procedure, the **retinal imaging photography** is highly recommended and can be an alternative to pupil dilation for many patients. The in-depth photograph of the structure of your retina allows our doctor to better examine and evaluate your eye health. The image also provides a permanent physical documentation of the retina.

A **visual field examination** determines to what degree you are able to see peripheral objects while fixated on a stationary object. It electronically measures retinal function. These tests allow us to provide a more thorough medical analysis of your eyes, not able to be provided through a routine eye examination and can assist in the early detection of many disorders including:

glaucoma, brain tumors, diabetic retinopathy, retinal detachments, hypertensive retinopathy, macular degeneration, optic nerve diseases, high blood pressure, cardiovascular disease and precancerous and cancerous lesions and many other conditions which can manifest itself in the eye.

Our doctors encourage all of their patients to have these tests performed as part of their annual comprehensive eye exam.

There is $35 charge for the Wellness Package testing as it is not covered by insurance. This fee is due at the time of your exam and is an eligible expense for FSA/HAS accounts.

______ I elect to have the Wellness Testing performed

____Retinal Image Photography

____Visual Field Screening

______ I decline to have the Wellness testing performed

Patient Name____ Date ___________