



Name: _____ Clinic Location: _____

(Please Print)

Date of Birth: _____

Gender: Male Female

Age: _____

Today's Date: _____

Are you covered by: Medicaid Medicare

We appreciate referrals, who may we thank for referring you to Prairie Eye Clinic? _____

VISUAL SYMPTOMS - (Please indicate any problems you are currently having with your current spectacles or contacts)

- | | | | |
|--|-----------------------------------|-------------------------------------|---------------------------------------|
| <input type="radio"/> Blur at distance (Driving) | <input type="radio"/> Itchy Eyes | <input type="radio"/> Eye Pain | <input type="radio"/> Glare / Halos |
| <input type="radio"/> Blur at near (Reading) | <input type="radio"/> Red Eyes | <input type="radio"/> Burning Eyes | <input type="radio"/> Seeing Floaters |
| <input type="radio"/> Difficulty seeing at night | <input type="radio"/> Watery Eyes | <input type="radio"/> Headaches | <input type="radio"/> Seeing Flashes |
| <input type="radio"/> Light Sensitivity | <input type="radio"/> Dry Eyes | <input type="radio"/> Double Vision | <input type="radio"/> Other |

REVIEW OF SYMPTOMS - Do you have problems with any of the following (if yes, please circle or list)

- | Yes | No | |
|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | Eyes -- Glaucoma / Cataract / Lazy Eye / Retina Disease / _____ |
| <input type="radio"/> | <input type="radio"/> | Endocrine -- Diabetes / Thyroid Problems / _____ |
| <input type="radio"/> | <input type="radio"/> | Cardiovascular -- High Blood Pressure / High Cholesterol / Heart Disease / _____ |
| <input type="radio"/> | <input type="radio"/> | Constitutional -- Fever / Weight Loss / Weight Gain / _____ |
| <input type="radio"/> | <input type="radio"/> | Ear, Nose, Throat, Mouth -- Sinus Problems / Sore Throat / _____ |
| <input type="radio"/> | <input type="radio"/> | Respiratory -- Cough / Asthma / Emphysema / _____ |
| <input type="radio"/> | <input type="radio"/> | Gastrointestinal -- Diarrhea / Reflux / Pain / _____ |
| <input type="radio"/> | <input type="radio"/> | Genitourinary -- Kidney Problems / Prostate Problems / _____ |
| <input type="radio"/> | <input type="radio"/> | Integumentary -- Skin Dryness / Rosacea / _____ |
| <input type="radio"/> | <input type="radio"/> | Musculoskeletal -- Arthritis / Joint Pain / Swollen Joints / _____ |
| <input type="radio"/> | <input type="radio"/> | Neurological -- Numbness / Headaches / Nausea / Multiple Sclerosis / _____ |
| <input type="radio"/> | <input type="radio"/> | Hematological/Lymphatic -- Blood Disorders / Leukemia / Anemia / _____ |
| <input type="radio"/> | <input type="radio"/> | Allergic/Immunologic -- Hay Fever / Seasonal Allergies / _____ |
| <input type="radio"/> | <input type="radio"/> | Psychiatric -- Depression / Anxiety / ADHD / _____ |
| <input type="radio"/> | <input type="radio"/> | Others -- Cancer / _____ |
| <input type="radio"/> | <input type="radio"/> | Women -- Pregnant / Nursing / _____ |

PAST HISTORY - please list past injuries or surgeries

Family Physician Name: _____

MEDICATIONS - please list any medications you take

Medication Allergies: _____

FAMILY HISTORY - Do your family members have any of the following?

- | Yes | No | | Yes | No | | Yes | No | |
|-----------------------|-----------------------|----------------------|-----------------------|-----------------------|----------------------|-----------------------|-----------------------|---------------------|
| <input type="radio"/> | <input type="radio"/> | Glaucoma | <input type="radio"/> | <input type="radio"/> | Diabetic Retinopathy | <input type="radio"/> | <input type="radio"/> | Diabetes |
| <input type="radio"/> | <input type="radio"/> | Macular Degeneration | <input type="radio"/> | <input type="radio"/> | Retinal Detachment | <input type="radio"/> | <input type="radio"/> | High Blood Pressure |
| <input type="radio"/> | <input type="radio"/> | Cataracts | <input type="radio"/> | <input type="radio"/> | Blindness | <input type="radio"/> | <input type="radio"/> | Other |

- | Yes | No | |
|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | Do you have prescription sunglasses? |
| <input type="radio"/> | <input type="radio"/> | Do you have more than 1 pair of current eyeglasses? |
| <input type="radio"/> | <input type="radio"/> | Do you use a computer? |
| <input type="radio"/> | <input type="radio"/> | Are you interested in discussing / wearing contact lenses? |
| <input type="radio"/> | <input type="radio"/> | Are you interested in discussing LASIK? |

SOCIAL HISTORY

Occupation: _____

Hobbies: _____

- | Yes | No | |
|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | Do you smoke? |
| <input type="radio"/> | <input type="radio"/> | Do you drink alcohol? |
| <input type="radio"/> | <input type="radio"/> | Do you use drugs? |

Dilation of the pupil is a common procedure used to better examine the inside of the eye. It allows us to detect and/or monitor conditions of the eye such as glaucoma and macular degeneration as well as diseases of the body such as diabetes and hypertension. Eye drops used to dilate your pupils last 4 to 6 hours. Light sensitivity and blurred vision, especially at near, are common. There are few risks to this procedure.

- Yes, perform a dilated exam No, I decline dilation today I want more information

Patient's Signature

Date

Reviewed On: date/initials: _____