WELCOME TO OUR OFFICE

We will be happy to help you fill out this form, ask for assistance.

Mr.
Mrs.
Ms. _____
Dr. First Name MI Last Name

COMPREHENSIVE EXAM WITH PUPIL DILATION: (Pupil enlargement)

Disease has no schedule, without enlarging the pupils, the doctor is unable to view 70 to 80% of your retinas. In order to **thoroughly** examine the inside of the eye for problems such as **glaucoma, cataract**, **retinal holes**, **tears**, **detachments** and **diseases**, it is necessary to place drops in your eyes to enlarge the pupils. **The side effects are blurred vision and light sensitivity**. In some individuals, the distance vision may also be blurred. However, because this procedure allows the doctor to have a broader view inside the eye to see detail that is not possible to view in the undilated eye, we recommend routine dilation whenever possible (especially for individuals with history of **high blood pressure** or **diabetes**).

Signature required:

I DO WANT pupil dilation_____ **I DECLINE pupil dilation**_____

Cell Ph._____ E-mail _____Home Ph._____

Preferred contact method (please circle): Text E-mail Phone Text & E-mail

Address_____ City_____ St._____ Zip_____

Date of Birth_____Social Security No._____

Occupation _____ Sex: _____F_____M

Emergency contact/Telephone #_____

If personally referred, whom may we thank for the referral_____

Insurance:_____

GENERAL HEALTH HISTORY:

	Yes	No		Yes	No		Yes	No
Diabetes	___	___	Cancer	___	___	Thyroid problems	___	___
Hypertension	___	___	Heart problems	___	___	Are you pregnant?	___	___
Arthritis	___	___	Asthma	___	___	Use cigarettes/tobacco?	___	___
Alcohol?	___	___	Medications	___	___	List:_____		
HIV+	___	___	Other Substance	___	___	List:_____		
			Known Allergies/Reactions:	___	___	List:_____		
						Reaction Type:_____		

Name of family doctor?_____Last Visit_____

EYE HISTORY:

Reason for visit? (If any): _____

	Yes	No		Yes	No		Yes	No	
Sinus problems	___	___	Burn, Itch or tear	___	___	Glaucoma	___	___	Any Family Health/Eye Condition?
Headaches	___	___	Recent eye infect.	___	___	Cataract	___	___	Yes_____No____Please List:
Eye injury	___	___	Floaters	___	___	"Lazy Eye"	___	___	_____
Eye surgery	___	___	Eye Drops	___	___				_____
Light flashes	___	___	Name of eye drop:_____						

Date of last exam: _____ Dilated?_____ Last eye doctor:_____