Medical History

Account #

Last eye-exam date ____________________ By Whom _____________________ In the City, State of _______________

Do you or your immediate family have any of the following medical conditions:

Self	Family	Whom?	Condition	Self	Family	Whom?	Condition	Self	Family	Whom?	Condition
❑	❑	________	Allergy	❑	❑	________	Nervous system	❑	❑	________	Lazy Eye / Eye turn
❑	❑	________	High Cholesterol	❑	❑	________	Skin	❑	❑	________	Cataract
❑	❑	________	Diabetes	❑	❑	________	Ear/Nose/Throat	❑	❑	________	Macular Degeneration
❑	❑	________	Arthritis	❑	❑	________	Blood/Lymph	❑	❑	________	Glaucoma
❑	❑	________	Migraines	❑	❑	________	Respiratory	❑	❑	________	Blindness
❑	❑	________	Thyroid condition	❑	❑	________	Gastrointestinal	❑	❑	________	Eye Surgery what type?
❑	❑	________	Heart Trouble	❑	❑	________	Kidney problem				
❑	❑	________	High Blood Pressure								________________

Your current Height: _________ Weight: _________

Do you:

❑ Smoke? How much? _________ ❑ Drink alcohol? How much? _______ ❑ Currently Pregnant? At ____ week(s)

❑ Current Medication ❑ Allergic Medication /substance(s)

____ ___________________________________

Tell us about your Lifestyle :

❑ Reading ❑ Driving ❑Computer : __ hr/ day ❑ Sport what type?________________

Do you wear contacts?: ❑ Soft ❑Hard ❑ Ortho-K ❑ Color Brand?___________________

Do you have any UV-blocking eyewear? ❑ Yes ❑ No

Are you here for:

❑ eyeglasses ❑ contact lenses ❑ both ❑ something else?

What else can we help you today?

❑ Blurry ❑ Glare ❑ Double ❑ Flashes ❑ Floater ❑ Red

❑ Dry eye ❑ Pain ❑ Watery ❑ Burning ❑ Itchy

Are you i*nterested in knowing more about*:

❑ Computer glasses ❑ Contact lens ❑ Orthokeratology Therapy ❑ Sports goggle ❑ Low-Vision ❑ LASIK

If you are having an eye examination for contact lenses, the evaluation fees start at $50 and will be collected in addition to your basic eye examination. If you would like a contact lens examination, circle 'Yes' to agree to a contact lens service charge. (This includes evaluation, lens design and follow-up services within 3 month. Fee is dependent upon complexity assessment.)

Yes ***No, I declined***

Combining Retinal Imaging and Optical Coherence Tomography technology, these tests allow our doctors to digitally record the internal structures of the eye and analyze and spot problems even before you have any symptoms. The image helps our doctor to monitor changes in the optic nerve, retinal blood vessels, and macula. For those with high degrees of myopia, glaucoma, diabetes, high blood pressure, high cholesterol, retinal detachments, or a family history of any of the aforementioned conditions, this service is HIGHLY recommended. This is an important test to monitor your retina for wellness annually. There is a small $59 charge for this service. Circle ‘Yes’ if you would like this service.

Yes ***No, I declined***

It may be necessary to have your eyes dilated today during the course of the examination. Possible side effects are blurriness and sensitivity to light. I hereby waive and relinquish any claim for damages against Spectrum Optometry and its doctors for such aforementioned dilation application. I also hereby acknowledge the omission of an eye dilation procedure and its inherent risk. If I decline this procedure during today's visit, I understand that a separate fee at a later date may apply. By circling 'Yes,' I agree to have this procedure done today.

Yes ***No, I declined***

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By signing, I have read and agreed to the above statements. Date