INSIGHT VISION CENTER

NAME _____ DOB _____ *GENDER* M / F

Date _____

VISUAL SYMPTOM (Please indicate any problems you are currently having with your current glasses or contacts)

☐ Blur at distance	☐ Itchy eyes	☐ Eye pain	☐ Glare / Halos
☐ Blur at near	☐ Red eyes	☐ Burning eyes	☐ Seeing floaters
☐ Difficulty seeing at night	☐ Watery eyes	☐ Headaches	☐ Seeing flashes
☐ Light sensitivity	☐ Dry eyes	☐ Double vision	☐ Other:

(Please circle any problems you have with any of the following)

Eyes Glaucoma / Cataract / Lazy eye / Retina Disease
Constitutional Developmental Disability/ Cancer / Fatigue
Ear, Nose, Throat, Mouth Hearing Loss / Sinusitis / Dry Mouth / Laringitis
Neurological MS / Epilepsy / Cerebral Palsy / Tumor / Stroke / Migraines / Autism
Psychiatric Depression / ADHD / Anxiety / Bipolar
Cardiovascular Blood Pressure / Stroke / Heart Disease / Vascular Disease / Congestive Heart Failure
Respiratory Asthma / Bronchitis / Emphysema / COPD / Sleep Apnea
Gastrointestinal Chron's / Colitis / Ulcers / Acid Reflux / Celiac Disease
Genitourinary Kidney Disease / Prostate Cancer / STD
Musculoskeletal Osteoarthritis / Arthritis / Fibromyalgia / Muscular Dystrophy / Ankolosing Spondylitis / Osteoporosis / Gout
Integumentary Eczema / Rosaea / Cold Sores / Shingles (Zoster) / Psoriasis
Endocrine Diabetes / Thyroid / Hormonal Dysfunction
Hematological / Lymphatic Anemia / High Cholesterol
Allergic / Immune Enviromental Alergies / Rheumatoid Arthritis / Lupus / Sjojren's Syndrome
Others / Cancer
Women - Pregnant

EYE HISTORY (List any injuries or surgeries)	**Medications** (List all medications you take)
LAST EYE EXAM:	
Family Physician:	**Med Allergies:**

FAMILY HISTORY

YES	NO		YES	NO	
☐	☐	Glaucoma	☐	☐	Retinal Detachment
☐	☐	Macular Degeneration	☐	☐	Blindness Other:
☐	☐	Cataracts	☐	☐	Diabetes
☐	☐	Diabetic Retinopathy	☐	☐	High Blood Pressure

SOCIAL HISTORY

Occupation _____

YES	NO		YES	NO	
☐	☐	Do you use drugs?	☐	☐	Are you interested in contact lenses?
☐	☐	Do you drink alcohol?	☐	☐	Do you use a computer?
☐	☐	Do you smoke? --------->	☐	☐	Are you interested in discussing LASIK?

Hobbies_____

Current Everyday Smoker Some Day Smoker

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 4-6 hours. Light sensitivity and blurred vision, especially at near, are common. There are few risks to this procedure, and no cost to you.

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

Signature on File This signature authorizes us to communicate to insurance companies on your behalf.

Patients Signature_____ Date_____