WELCOME TO OUR OFFICE

Please Print
Important: This questionnaire is reviewed at each appointment.
Please answer all questions. **Date _____/_____/____**

Gender: □ Male □ Female Patient's Name(Last, First) _____ DOB _____ Age _____
Address _____ City _____ State _____ Zip Code _____
Email Address _____ Contact # _____ Cell/Alt. # _____
Occupation _____ Employer/School _____ Social Security # _____/_____/_____
Name of Parent/Guardian/Spouse/Partner _____ Phone No_____
Emergency Contact Name _____ Emerg. Contact Phone # ( ) _____
New Patient □ YES □ NO Referred By: _____
Reason For Toady's Visit _____

PERSONAL EYE HEALTH HISTORY

Date of Last Eye Exam _____

Do you wear glasses? □ Yes □ No
□ All the Time □ Occasionally
□ Reading □ Driving □ TV

Do you wear contacts? □ Yes □ No
Type_____

Are you interested in wearing contacts?
□ Yes □ No

Place a mark to indicate if you have had any of the following

BLURRED VISION	□	**HEADACHES/MIGRAINES**	□
BURNING EYES	□	**ITCHING EYES**	□
CATARACTS	□	**LIGHT SENSITIVE/GLARE**	□
CROSSED EYES	□	**LOSS OF VISION**	□
DISCHARGE FROM EYES	□	**MACULAR DEGENERATION**	□
DOUBLE VISION	□	**POOR COLOR VISION**	□
DRYNESS	□	**POOR NIGHT VISION**	□
EYE PAIN/SORENESS	□	**RED EYES**	□
EYELID PROBLEM	□	**RETINA DETACHMENT/DISEASE**	□
FLOATERS/FLASHES	□	**TEARING/WATERING**	□
FOREIGN BODY SENSATION	□	**TIRED EYES**	
GLAUCOMA	□	**OTHER _____**	

Does your work require special vision care? If Yes Please Explain: _____

Have you had any eye surgeries? □ Yes □ No Type _____

Have you had any eye injuries? □ Yes □ No Type _____

MEDICAL INFORMATION

Family Dr. _____ Last Visit _____ Tel. ( ) _____

Place a mark to indicate if you or a blood relative have had any of the following. (Please indicate which relative)

	SELF	FAMILY MEMBER		SELF	FAMILY MEMBER
AIDS/HIV	□	□ _____	**HIGH BLOOD PRESSURE**	□	□ _____
ANEMIA	□	□ _____	**KIDNEY DISEASE/DIALYSIS**	□	□ _____
ARTHRITIS/	□	□ _____	**LUPUS**	□	□ _____
ASTHMA	□	□ _____	**MACULAR DEGENERATION**	□	□ _____
BELL'S PALSY	□	□ _____	**MIGRAINE HEADACHES**	□	□ _____
BLEEDING PROBLEM	□	□ _____	**NEUROLOGICAL PROBLEM**	□	□ _____
BLINDNESS	□	□ _____	**RETINA DETACHMENT**	□	□ _____
CANCER	□	□ _____	**RETINAL DISEASE**	□	□ _____
CATARACTS	□	□ _____	**SARCOIDOSIS**	□	□ _____
CHEMICAL DEPENDENCY	□	□ _____	**SEIZURES/DIZZY SPELLS**	□	□ _____
CHRONIC BRONCHITIS	□	□ _____	**SHINGLES**	□	□ _____
DIABETES	□	□ _____	**SICKLE CELL/TRAIT**	□	□ _____
DRUG SENSITIVITY	□	□ _____	**SKIN CONDITIONS**	□	□ _____
EMPHYSEMA	□	□ _____	**STROKE**	□	□ _____
EYE SURGERY	□	□ _____	**THRYROID CONDITION**	□	□ _____
GLAUCOMA	□	□ _____	**TUBERCULOSIS**	□	□ _____
HEART CONDITION	□	□ _____	**PREGNANT (CURRENTLY)**	□	
HEPATITIS (Type _____)	□	□ _____	**OTHER _____**		

--- OVER ---

SOCIAL HISTORY

Use of Alcohol	□ Never	□ Occasionally	□ Regularly
Use of Tobacco	□ Never	□ Previously	□ Current
Use of Recreational Drugs	□ Never	□ Previously	□ Current

MEDICATIONS
List medications you are currently taking, including eye drops:

_____

_____

_____

ALLERGIES
List your allergies to medications or other substances:

_____

_____

_____

DILATION FUNDUS EXAMINATION
Pupil dilation allows a doctor to examine the retina for holes, tears, detachments, tumors (benign or malignant), leaking blood vessels and other retinal anomalies. Dilation is especially helpful in the diagnosis of glaucoma, cataracts, unexplained vision loss, and even brain tumors. People with a personal or family history of headaches, diabetes, hypertension, or who have high prescription are highly recommended to have their eyes dilated.

The most common side effects of the drops used are increases glare and reduction in near focusing ability. Distance vision is not significantly affected so you should be able to drive. The process is painless and lasts approximately 3 to 5 hours. Please indicate below if you give permission for dilating drops to be used.

I agree_____ **or** I refuse _____ to have my (or my child's) eyes dilated today.

Doctor's Review _____ **Date** _____

OFFICE POLICIES
Contact Lens Prescriptions **will not** be given until a proper evaluation has been established and all professional services are paid in full. Contact Lens prescriptions **MUST** be finalized within 60 (sixty) days from the original date of exam, or another contact lens evaluation fee will be charged. **ALL PROFESSIONAL FEES ARE NON REFUNDABLE** Please sign below indicating you have read, understand, and agree to the office policies as stated above.

ASSIGNMENT AND RELEASE
I, the undersigned certify that I (or my dependent) have insurance with _____ and assign Stone Mountain Eye Center all insurance benefits otherwise payable to me for services rendered. I understand I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to submit information necessary to secure benefits. I authorize the use of this signature on all insurance submitted.

Patient/Guardian Signature: _____Date:_____

OFFICE USE
ADJUSTMENTS: _____ (PRIMARY) : _____ (SECONDARY)