Welcome to Atlantic Eye Center

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

Thank you for choosing our practice. To better serve you. please fill out the information below to the best of your ability and bring insurance card to the front.

Date _____ Chart # _____

Patient Name _____ Sex _____ Birth date _____

Soc Sec # _____ Primary Care Physician _____

Address _____ City _____ State _____ Zip: _____

Phone: Home _____ Work _____ Cell _____

Employer _____ Email _____

In case of Emergency, Contact _____ Phone _____

EYE HISTORY

Do you currently wear ☐ Glasses ☐ Contact Lenses ☐ Neither

Do you have visual difficulty when reading? ☐ No ☐ Yes Do you have visual difficulty when driving? ☐ No ☐ Yes

Dilating the Eye: Dilating your eyes allows for a more detailed examination of the inside of your eye. Possible side effects are glare and blur. Do not drive or operate machinery unless you are absolutely comfortable.

☐ I do want to have my eyes dilated
☐ I do NOT want to have my eyes dilated _____ (Initial) _____ (Date)

Are you currently pregnant or nursing? ☐ No ☐ Yes

Have you ever had eye surgery? ☐ No ☐ Yes

If yes, please describe:

Right Eye Left Eye Type of surgery _____ Date _____

Have you ever injured your eye? ☐ No ☐ Yes

If yes please describe _____

Have you ever had any of the following eye conditions?

			Check here if you are currently experiencing this condition				Check here if you are currently experiencing this condition
Glaucoma	☐ No	☐ Yes	☐	Halos	☐ No	☐ Yes	☐
Macular degeneration	☐ No	☐ Yes	☐	Sensitivity Light	☐ No	☐ Yes	☐
Cataracts	☐ No	☐ Yes	☐	Redness	☐ No	☐ Yes	☐
Retinal tear or detachment	☐ No	☐ Yes	☐	Itching	☐ No	☐ Yes	☐
Lazy Eye /wandering Eye	☐ No	☐ Yes	☐	Burning	☐ No	☐ Yes	☐
Eye Pain	☐ No	☐ Yes	☐	Dryness	☐ No	☐ Yes	☐
Blurred Vision	☐ No	☐ Yes	☐	Sandy/gritty sensation	☐ No	☐ Yes	☐
Decreased vision	☐ No	☐ Yes	☐	Foreign body sensation	☐ No	☐ Yes	☐
Double vision	☐ No	☐ Yes	☐	Discharge	☐ No	☐ Yes	☐
Flashes of light in eye(s)	☐ No	☐ Yes	☐	Crusting eyelids	☐ No	☐ Yes	☐
Floating dark spots in eye(s)	☐ No	☐ Yes	☐	Drooping eyelid	☐ No	☐ Yes	☐

Other _____

MEDICAL HISTORY

Please provide your: Height _____ Weight _____

Have you ever been treated for a serious illness or medical condition? ☐ No ☐ Yes

If yes, please explain _____

Have you had any hospitalizations or surgery? ☐ No ☐ Yes

If yes, please explain _____

Please list any medications that you take, prescription or non-presciption:

_____

Drug Allergies	☐ No	☐ Yes	Please list _____
Food Allergies	☐ No	☐ Yes	Please list _____
Latex Allergies	☐ No	☐ Yes	

Please Fill Out Front & Back →

Patient Name _____ **Chart #** _____

MEDICAL HISTORY (CONT.)

Review of System:

Are you currently experiencing problems with any of the following?

Constitutional	Yes	No
Fever, Weight Loss/Gain	☐	☐
Other _____		

IntegulImmunologic	Yes	No
Aids	☐	☐
Herpes Simplex	☐	☐
Herpes Zoster	☐	☐
HIV Positive	☐	☐
Histoplasmosis	☐	☐
Lyme Disease	☐	☐
Reye's Disease	☐	☐
Sarcoidosis	☐	☐
Sjogren's Syndrome	☐	☐
Other _____		

Ear/Nose/Mouth/Throat/Head	Yes	No
Allergies	☐	☐
Sinus Congestion	☐	☐
Post Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Mouth/Throat	☐	☐
Hearing Loss - Full	☐	☐
Hearing Loss - Impaired	☐	☐
Meniere's Syndrome	☐	☐
Other _____		

Psychiatric	Yes	No
ADHD	☐	☐
Alzheimer's Disease	☐	☐
Autism	☐	☐
Bi-Polar Disorder	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Other _____		

Cardiovascular	Yes	No
Heart Disease	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Stroke	☐	☐
Vascular Disease	☐	☐
Other _____		

Gastrointestinal	Yes	No
Colitis	☐	☐
Gardner's Syndrome	☐	☐
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Ulcer/Reflux	☐	☐
Gastroenteritis	☐	☐
Other _____		

Genito-Urinary	Yes	No
Bladder/Genital/Kidney	☐	☐
PCOS	☐	☐
Prostrate	☐	☐
Other _____		

Musculoskeletal	Yes	No
Joint/Muscle Pain	☐	☐
Osteo Arthritis Pain	☐	☐
Rheumatoid Arthritis	☐	☐
Marfan's Syndrome	☐	☐
Muscular Dystrophy	☐	☐
Padgett's Disease	☐	☐
Scoliosis	☐	☐
Other _____		

Integumentary (Skin)	Yes	No
Skin Cancer	☐	☐
Skin Disease	☐	☐
Herpes Zoster/ Shingles	☐	☐
Lupus	☐	☐
Albinism	☐	☐
Psoriasis	☐	☐
Other _____		

Respiratory	Yes	No
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Other _____		

Neurological	Yes	No
Headaches	☐	☐
Migraines	☐	☐
Multiple Sclerosis	☐	☐
Seizures	☐	☐
Bell's Palsy	☐	☐
Cerebral Palsy	☐	☐
Vertigo	☐	☐
Homer's Syndrome	☐	☐
Von-Hippel-Lindau Disease	☐	☐
Myasthenia Gravis	☐	☐
Paralysis	☐	☐
Other _____		

Endocrine	Yes	No
Diabetes Type I	☐	☐
Diabetes Type II	☐	☐
Diabetes Suspect	☐	☐
Thyroid/Other Glands	☐	☐
Crohn's Disease	☐	☐
Gout	☐	☐
Other _____		

Lymphatic	Yes	No
Hematologic	☐	☐
Anemia	☐	☐
Bleeding Problems	☐	☐
Hodgkin's Disease	☐	☐
Leukemia	☐	☐
Sickle Cell Disease	☐	☐
Thalassemia	☐	☐
Other _____		

FAMILY HISTORY

Mark yes or no to each entry. If yes, list which family member including mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather

Ambiyopia (Lazy Eye)	☐ Yes	☐ No	_____	Strabismus (cross eyes)	☐ Yes	☐ No	_____
Blindness and /or vision impairment	☐ Yes	☐ No	_____	Arthritis	☐ Yes	☐ No	_____
Cataract	☐ Yes	☐ No	_____	Cancer	☐ Yes	☐ No	_____
Macular Degeneration	☐ Yes	☐ No	_____	Diabetes	☐ Yes	☐ No	_____
Glaucoma	☐ Yes	☐ No	_____	Hypertension (High blood pressure)	☐ Yes	☐ No	_____
Retinal disorder	☐ Yes	☐ No	_____	Cardiovascular disease	☐ Yes	☐ No	_____
				Stroke	☐ Yes	☐ No	_____

SOCIAL HISTORY:

Marital Status ☐ **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Use of alcohol ☐ **Never** ☐ **Rarely** ☐ **Moderate** ☐ **Daily**

Use of tobacco ☐ **Never** ☐ **Previously but not in the past** _____ **years** **Yes** _____ **packs/day**

To the best of my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the doctor's office of any changes in my medical status.

_____ _____

Signature of patient (or guardian, if minor) Date

Atlantic Eye Optometric Services, P.A

Patient Consent Form

-Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patients Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

-You have the right to request how we restrict protected health information is used or disclosed for treatment, payment of health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

-By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

This consent was signed by: _____ _____

Printed Name Signature

Patient Name: _____

Relationship to Patient (if other than patient): _____

Please list names of family members or friends who have permission to discuss your medical history with this office.

i. _____

ii. _____

iii. _____

OptoMap® Retinal Exam

_____ Yes, I want the Optomap® digital images and would like for the doctor to review them with me today. I understand the doctor recommends having an annual Optomap®. Also, in most cases this can be done in place of dilation if normal retinal findings are present. ***NOTE: OUR FEE IS $35.00****

_____ No, I do not want the Optomap® digital images. By declining this screening, I elect to have my eyes dilated.

I understand the benefits of the annual Optomap® Retinal Exam as:

- Fast, easy, & comfortable
- A permanent record to compare and track potential eye diseases.
- An in-depth view of nearly the entire retina
- Educational tool for your doctor to discuss your health and wellness.

I understand that a widefield view of the retina is an important part of a comprehensive eye exam and my doctor recommends having the back of my eye documented with digital imaging.

Patient's Signature: _____

Date: _____