Pelini Eyecare: Patient History Form
Please Print

Today's Date _____ Date of Birth _____
Name (Last, First, M.) _____
Address_____ City/State _____ Zip _____
Phone (cell) _____ (work) _____ SSN_____
Marital Status: Married ___ Single ___ Other ___ Email _____
Insurance Co_____ Policy Owner _____
ID Number_____ Relationship to Insured _____
Occupation _____ Employer _____
Emergency contact/phone _____ Relationship _____
Name of Primary Care Physician_____ Phone _____
When was your last physical? _____Last eye exam? _____
Whom may we thank for referring you? _____

OCULAR HISTORY:

Do your eyes burn, itch, tear up or get red? Y / N
Do you see flashing lights, floaters or see double? Y / N
Do you have frequent or severe headaches? Y / N
Is your vision blurry even with correction? Y / N
Have you ever had eye surgery? Y / N
List any other eye problems you are experiencing _____

Have you been diagnosed with any of the following?		**List any family members with these conditions:**
Cataracts	Y / N	_____
Diabetic eye disease	Y / N	_____
Glaucoma	Y / N	_____
Macular degeneration	Y / N	_____
Retinal detachment	Y / N	_____
Other eye conditions	Y / N	If yes, please elaborate: _____

MEDICAL HISTORY: **Do you have any problems with:**		**If yes, please elaborate:**
Allergies	Y / N	_____
Blood/Lymphatic (Ex: HIV, anemia)	Y / N	_____
Cardiovascular (Ex: High Blood Pressure)	Y / N	_____
Cancer	Y / N	_____
Endocrine (Ex: Diabetes)	Y / N	_____
Ear, Nose, Throat	Y / N	_____
Gastrointestinal	Y / N	_____
Genitourinary	Y / N	_____
Immunologic (Ex: Arthritis)	Y / N	_____
Integumentary/Skin	Y / N	_____
Musculoskeletal	Y / N	_____
Neurological	Y / N	_____
Psychiatric	Y / N	_____
Respiratory	Y / N	_____
Are you pregnant/ breastfeeding	Y / N	

Are you allergic to any medications? _____
List current medications _____
Do you use tobacco? Y / N Alcohol? Y / N Recreational substances? Y / N

I assert that the information provided on this page is complete and truthful to the best of my knowledge.

Signed: _____ Date: _____

Pelini Eyecare: Patient Lifestyle Questionnaire

Patient Name _____ Date_____

Thank you for taking a few minutes to complete this questionnaire. The information you provide will help us better understand your vision care needs.

Current Ocular Status

What is the primary reason for your visit today? _____

Are your current **Glasses**...?

____ Don't wear glasses
____ Used to see far away
____ Used to see computer/read
____ Lined Bifocals
____ Progressive (No-line) bifocals
____ Not sure

Are your current **Contact Lenses**...? (Check all that apply)

____ Don't wear contacts
____ Disposable (Daily/2 weeks/Monthly)
____ Overnight wear
____ Gas permeable (Hard)
____ Bifocal or monovision
____ Not sure

Would you like more information about LASIK? Y / N
Do you have UV protective sunglasses? Y / N
Are you interested in lenses that darken in sunlight? Y / N
Do you experience any problems with glare while driving at night or at the computer? Y / N

Occupation/Recreation

Do you perform fine or up-close work? Y / N
How many hours do you spend on the computer each day? _____
Do you participate in any of these sports or recreational activities? (Check all that apply)

____ Boating/water sports
____ Cycling/Motorcycling
____ Fishing
____ Golfing
____ Gardening
____ Hiking
____ Jogging/Walking
____ Reading
____ Sewing/Knitting
____ Skiing/Snow sports

Other _____

Dilation

Dilation is an integral part of a comprehensive eye examination and is *included at no additional cost*. The thorough evaluation of the posterior structures of the eye (including the retina and optic nerve) requires drops to temporarily enlarge the pupils. This is especially important for patients who: are highly nearsighted, are over 40 years old, or have any conditions that affect their general health (**diabetes, high blood pressure,** etc.). The drops make you sensitive to light &/or impair your ability to do near work (reading) for approximately 2-6 hours.

Please check one:

____ Yes, I would like to be dilated today
____ Yes, I would like to be dilated but will reschedule for another day (no additional charge)
____ No, I would not like to be dilated and understand that my exam will be incomplete

Visual Field

Our Humphrey FDT Visual Field machine measures retinal function and field of vision. This measurement assists us in the early detection of many disorders including brain tumors, glaucoma, diabetic retinopathy, and retinal detachments. We strongly recommend that all patients receive the screening annually, especially for patients who are highly nearsighted, or those with headaches, flashes of light, high blood pressure or diabetes, or have a family history of glaucoma.

The $10 charge for the Visual Field test is not covered by most insurance plans.

____ Yes, I would like to do the Visual Field test today
____ No, I do not want the Visual Field test

Please initial: _____