# Patient History Form

(Please Print)

| NAME | EMAIL ADDRESS | MALE<br>FEMALE | BIRTH DATE | OCCUPATION |
|---|---|---|---|---|
| STREET | CITY | STATE | ZIP | PHONE |

**What is the main reason for your visit?**

Do you wear glasses? ☐Y ☐N
If yes, do you wear them for: DIST, NEAR, BOTH
Do you wear contact lenses? ☐Y ☐N
Date of your last eye exam? _____
Date of your last medical exam? _____
Do you have any allergies to medication? ☐Y ☐N
LIST:
_____
_____
Do you suffer from headaches? ☐Y ☐N
Do you suffer from seasonal allergies? ☐Y ☐N
Are you taking any medications? ☐Y ☐N
Are you Pregnant? ☐Y ☐N

Do you see flashes of lights in your eyes? ☐Y ☐N
Do you see floating objects in your eyes? ☐Y ☐N
Do you suffer from temporary blackouts of your vision? ☐Y ☐N

**LIST MEDS:**
_____
_____
_____
_____
_____

**LIST EYE MEDS:**
_____
_____
_____
_____
_____

**Do you suffer from:**

- ☐ NONE
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Lung Disease
- ☐ Cancer
- ☐ Rheumatoid Arthritis
- ☐ Sarcoidosis
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ HIV

**Have your eyes ever suffered from:**

- ☐ NONE
- ☐ Strabismus (eye turn)
- ☐ Amblyopia (lazy eye)
- ☐ Keratoconus
- ☐ Glaucoma
- ☐ Diabetic Retinopathy
- ☐ Macular Degeneration
- ☐ Dry Eyes
- ☐ Iritis
- ☐ Retinal Detachment
- ☐ Retinal Disease
- ☐ Optic Nerve Disease

**Have you had previous eye surgery for:**

- ☐ NONE
- ☐ Cataract
- ☐ Retinal Detachment
- ☐ Muscle Surgery
- ☐ Trauma
- ☐ Lasik/PRK
- ☐ Foreign Body Removal
- ☐ Other

**Has anyone in your family suffered from:**

- ☐ NONE
- ☐ Blindness
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Keratoconus

Doctor Initials: _____

## Acknowledgement of Receipt HIPAA

I acknowledge that I have received or been offered the HIPAA Notice of Privacy Practices which describes the uses and disclosures of my protected health information by the Practice and informs me of my rights with respect to my protected health information.

**Patient or Guardian (if under 18 years old) Signature:** _____ **Date:** _____

## Acknowledgement of Informed Consent

**Safety, Sports & Children's Glasses:** Polycarbonate and Trivex are considered the safest lens materials for children and for people involved in sports or other activities that involve danger of impact to the eyes and face. **Acknowledgement:** By signing this form, I acknowledge that I understand this safety notation and have answered all of the questions above to the best of my abilities.

**Patient or Guardian (if under 18 years old) Signature:** _____ **Date:** _____

➢ *If patient refused or could not sign, staff member should sign his or her own signature and reason above.*

# Exam Form

| NAME (print) | DOB | AGE | DATE | DOCTOR NAME | STORE # |
|---|---|---|---|---|---|
| | | | | | |

Previous ☐ New ☐ Contact Lens Today: ☐Y ☐N

**History:** Any changes in medical history from last visit ☐Y ☐N
**Chief Complaint:** ☐Distance Blur ☐Near Blur ☐Headaches ☐New glasses ☐ New Contacts

Head / Face: ☐ unremark
Psych: Mood / Affect
(anxiety/agitation/depression) ☐ unremark
Neuro: Orientated (person/place/time) ☐Y ☐N

**Pretest:**

| VA: | Unaided: NP | ∞ | w/specs/CLs NP | ∞ |
|---|---|---|---|---|
| OD | | 20/ | | 20/ |
| OS | | 20/ | | 20/ |
| OU | | 20/ | | 20/ |

**Color vision** _____
**Stereopisis** _____

| Tn: | OD | OS | TIME |
|---|---|---|---|
| NCT | | | am/pm |
| APP | | | am/pm |

Pre Tester Initials:_____

**Blood Pressure :**_____ am/pm

**Keratometry:** ☐see attached
OD: _____
OS: _____

**Old Glasses Rx:**
OD: _____
OS: _____
ADD: _____ SV / BI / TFL / PAL

**Autorefraction:** ☐see attached
OD: _____
OS: _____

**Subjective (Phoroptor) Rx:**
OD: _____ 20/
OS: _____ 20/
ADD: _____ 20/

**Near Testing:**
Work Dist: _____
NRA: _____ PRA: _____
Lateral:_____ Vertical:_____

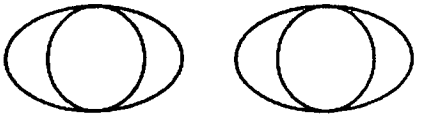
**Pupils:**
Size: R_____ L_____
PERRLA ☐Y ☐N
APD ☐Y ☐N

**Cover Test:** Dist ____ Near ____
Primary Gaze: ☐ Ortho or ☐ Tropia
Motility: ☐ Smooth & Full OU OR:
NPC: ☐ TTN OR: _____

**Ophthalmoscopy:** ☐Direct ☐Dilation ☐Optos
OD C/D H .1 .2 .3 .4 .5 .6 .7 .8 .9 1.0
V .1 .2 .3 .4 .5 .6 .7 .8 .9 1.0
OS C/D H .1 .2 .3 .4 .5 .6 .7 .8 .9 1.0
V .1 .2 .3 .4 .5 .6 .7 .8 .9 1.0

**Optic Nerve:** size/appear
OD ☐ Unremark ☐ Pathology
OS ☐ Unremark ☐ Pathology

**Retina/Macula:**
OD ☐ Unremark ☐ Pathology
OS ☐ Unremark ☐ Pathology



**Adnexa & Globe:**

| Angles | OD_____ | OS_____ |
|---|---|---|
| Lids | ☐ unrem | ☐ unrem |
| Lashes | ☐ unrem | ☐ unrem |
| Bulbar Conj | ☐ unrem | ☐ unrem |
| Palpeb Conj | ☐ unrem | ☐ unrem |
| Sclera | ☐ unrem | ☐ unrem |
| Ant. Chamb | ☐ unrem | ☐ unrem |
| Iris | ☐ unrem | ☐ unrem |
| Lens | ☐ unrem | ☐ unrem |
| Tear Film | ☐ unrem | ☐ unrem |
| Cornea | ☐ unrem | ☐ unrem |

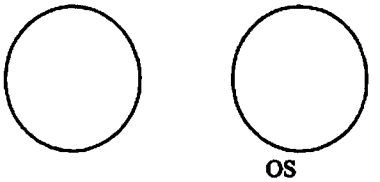
☐**Confront VF:** ☐ Unremark vs.

☐**Automated Fields:** ☐FDT ☐Other

**OD:** ☐ Unremark vs.:
**OS:** ☐ Unremark vs.:

**DFEX:**
OD:____ drops P M 1% .5% N 2.5% @_____
OS:____ drops P M 1% .5% N 2.5% @_____
**OTHER:** _____

☐ DFEX complete w/ BIO/20D 78D 90D (circle)



OD OS

| OD | | OS |
|---|---|---|
| _____ | C/D | _____ |
| _____ | Rim/Margin | _____ |
| _____ | A/V | _____ |
| _____ | F | _____ |
| _____ | Periphery | _____ |

**Notes:**

| Procedure Codes: | | |
|---|---|---|
| 92004 | 92014 | CL Check-Charge |
| CL Check - NC | Visual Fields | OPTOS |
| RE-VAL | Other: | |

**Counseled on (circle):**

| | | |
|---|---|---|
| DFEX | RD Sx's | Headache |
| Diabetes | HTN | Decreased VA |
| Glaucoma | Cats | EWCL |
| New Rx Adaption | ARMD | Polycarbonate |

| ICD-10-CM codes w respect to CC: | | |
|---|---|---|
| H52.01 | H52.02 | H52.03 |
| H52.11 | H52.12 | H52.13 |
| H52.221 | H52.222 | H52.223 |
| H52.4 | H25.9 | Z96.1 |

**Assessment:**

**Plan:**

Final Eyeglass RX:

| RX#1 | Sph | Cyl | Axis | Prism | Add |
|---|---|---|---|---|---|
| OD | | | | | |
| OS | | | | | |

| RX #2 | Sph | Cyl | Axis | Prism | Add |
|---|---|---|---|---|---|
| OD | | | | | |
| OS | | | | | |



MA CHA SMA PRESBYOPIA
Mixed Astig MYOPIA HYPEROPIA

Doctor Signature_____
RTO: 1YR 1WK (CL FU) OR _____
New – Current VWS# _____