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ROA
DWAY
VISION
CENTER

Patient History Form

Welcome to our office. Please take a moment to complete this form so we may help care for your eye health needs. Privacy of personal information is very important to us. We will only use the information necessary for the optometric services and products we provide.

Last Name: First Name: Initial:

Date of Birth / / Date of last exam: / /

Have you experienced any of the following?:

[ ] Frequent Headaches/ Migraines
[ ] Laser eye surgery
[ ] Eye Surgery
[ ] Double Vision
[ ] Sudden Loss of Vision

Ocular/ Medical History:

Glaucoma [ ] Self [ ] Family
Macular Degeneration [ ] Self [ ] Family
Cataracts [ ] Self [ ] Family
Thyroid [ ] Self [ ] Family
Heart [ ] Self [ ] Family
High Blood Pressure [ ] Self [ ] Family
Lazy Eye [ ] Self [ ] Family
Eye Turn [ ] Self [ ] Family
High Cholesterol [ ] Self [ ] Family
Diabetes [ ] Self [ ] Family
Color Vision Problem [ ] Self [ ] Family
Other:

Y= Yes N= No S= Sometimes

Do you currently wear contact lenses? [ ]
Have you tried contact lenses? [ ]
Do you currently wear glasses? [ ]
Far? [ ]
Near? [ ]
Both? [ ]

Please list all current medication/ vitamins:

Please list all allergies:

Dilation Consent/ Refusal

An important part of an eye exam is the dilated retinal examination. It involves putting dilation drops in the eye to evaluate the health of the inside of the eye: the retina, optic nerve and macula. It assists in detection of retinal disease, cataracts, glaucoma, retinal detachments, retinal breaks, macular degeneration and other important degenerative conditions. It is especially important if you: Have a systemic disease such as diabetes, high blood pressure, other medical conditions; have a high degree of nearsightedness (myopia); are experiencing reduced vision, floaters or flashes of light; have a family history of glaucoma, macular degeneration or other retinal disease. **Eye drops that are used in this procedure cause the pupil to be enlarged. Near vision may be affected for 2-6 hours and sensitivity to light might occur.** Most people do not experience difficulty with driving, but it varies with each individual. Use caution when walking, especially on stairs and curbs while vision is blurred.

I, _____, have been fully informed of the risks & benefits of a dilated eye exam.

Please choose and sign below

____ I choose to have my eyes dilated today
____ I would like to reschedule the procedure to be done on a different day
____ I choose not to have my eyes dilated today, understanding that a condition with potential for vision loss may exist and go untreated.

Signature _____ Date_____