*Welcome **back** to our office. Please take a moment to update your patient file. **Thank you.***

Name_____ **Date**_____

Contact Information:

- Same
- **New** Address_____ Apt_____

City _____ State_____Zip Code_____

Home Phone_____ Work Phone _____

Cell Phone_____ Email _____

Please check any of the following condition(s) that apply to today's visit.

__Blurred Distance Vision	__Watery Eyes	__Floaters	__Eye Pain	__Retinal Disorder
__Blurred Near Vision	__Dry Eyes	__Halos Around Light	__Eye Infection	__Macular Degeneration
__Eye Strain	__Itchy, Burning Eyes	__Flashes of Light	__Eye Injury	__Glaucoma
__Light Sensitive	__Red Eyes	__Eye Injury	__Eye Surgery	__Cataracts

__Other, please list _____

Please check if you have any of the following conditions and list the treatment for that condition:

- Ears/Nose/Throat/Mouth: Hearing Loss, Sinus Problems _____
- Respiratory: Short of breath, Wheezing, Asthma, Cough _____
- Heart: Chest Pain, Irregular Heartbeat _____
- Cardiovascular: High Blood Pressure _____
- Digestive: Heartburn, Diarrhea, Reflux _____
- Neurologic: Paralysis, Numbness _____
- Skin: Rashes, Eczema _____
- Psychiatric: Depression, Anxiety, Mental Illness _____
- Endocrine: Diabetes, Thyroid _____
- Cancer: Any Type _____
- Blood: Anemia, Sickle Cell, Excessive Bleeding _____
- Urinary: Kidney, Bladder Condition _____
- Other; Please list _____

Medications: Please list all current medications (prescription and over the counter).

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Dilated Examination: A dilated exam allows a more thorough view of the retina and can detect many conditions within the eye that may not be detected during a routine eye exam. Dilation is strongly advised for patients with a history of glaucoma, cataracts, diabetes, high nearsighted corrections, headaches, eye trauma, or any other conditions that affect the integrity of the retina. Your near vision will be impaired and you will also be light sensitive for approximately 4-6 hours. This procedure is included in the comprehensive exam.

- Yes, I agree to have the dilated exam.
- NO, I decline to have the dilated exam. I am aware of the risks associated with the failure to detect any eye conditions due to the lack of information that could have been obtained by this important procedure.

_____ _____

Patient's Signature or Patient's Legal Representative Date