

PATIENT WORK-IN FORM

(PLEASE PRINT)

PATIENT NAME: _____

DOB: _____

ADDRESS: _____

PHONE: _____

EMAIL: _____

VISION PLAN: _____

SUBSCRIBER - _____

SUBSCRIBER DOB - _____

Name: _____ Date of Birth: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

Last Eye Exam: _____ Where: _____

What brings you to the office today? _____

Allergies to medications	Reaction	Severity
_____	_____	mild/moderate/severe
_____	_____	mild/moderate/severe
_____	_____	mild/moderate/severe

Past Ocular History: (Circle all that apply)

Over all healthy Myopia (near sighted) Hyperopia (Far sighted) Amblyopia (lazy eye) Astigmatism

Contact Lens use Contact lens overwear Keratoconus Corneal Ulcer Dry eyes

Cataracts Glaucoma Narrow Angles Iritis Optic Neuritis Diabetic Retinopathy

Macular Degeneration Retinal Disease Trauma

Ocular Surgeries: (Circle all that apply)

Cataract Surgery Laser Capsulotomy (post cataract surgery) Lasik Strabismus/muscle surgery

RK PRK Corneal Transplant Punctal Plugs Blepharoplasty Foreign Body removal

Vitreotomy Retinal Laser Surgery Macular Degeneration Injections

Trabeculectomy Laser Surgery for Narrow Angles

Family History (other than yourself): (please circle applicable family members)

Unknown Family History

Glaucoma Parent/ Sibling/ Maternal Grandparent/ Paternal Grandparent

Macular Degeneration Parent/ Sibling/ Maternal Grandparent/ Paternal Grandparent

Blindness Parent/ Sibling/ Maternal Grandparent/ Paternal Grandparent

Other disease please list: _____

Ocular significant illnesses: (circle all that apply)

AIDS Herpes Hypothyroidism Hyperthyroidism Sjogren's disease HIV positive Lupus Diabetes

Hypertension Multiple Sclerosis Graves disease Rheumatoid Arthritis Neurological disorders

Systemic Illnesses: (circle all that apply)

Anemia Arthritis Arrhythmia Bleeding disorder Cancer Cholesterol Congestive Heart Failure
COPD Diabetes Eczema Fibromyalgia Headache Hearing loss Hepatitis Hypertension HIV
Kidney disease Kidney stones Liver disease Lung disease Lupus Migraine Polymyalgia Stroke
Psychiatric disorder Skin Cancer Thyroid disease Other please list:

Please list General Surgeries:

Current Eye Medications:

Current Systemic Medications: (supply a list or review printed list)

Social History: (please circle all that applies)

Smoking: Current smoker Vape use former smoker never smoked lives with a smoker

Alcohol use: Yes No

Recreational drug use: Yes No

Do you wear glasses? If yes, please circle all that apply:

Over the counter readers Progressive Bifocal Distance only Reading only

Do you have prism in your current prescription to correct double vision? _____

Contact lens patients please provide:

Brand of contacts: _____

Hours of wear: _____

Cleaning solution: _____

Brands that have not worked in the past: _____



Optomap Ultra-Widefield Imaging Technology

At **The Optical Shop**, we pride ourselves in providing our patients with the best possible standard of care. Because of this, our doctors strongly recommend that all patients have an Optomap® Retinal Exam. This non-invasive procedure allows your doctor to see a much broader and more detailed view of the retina than is possible with conventional methods. When reviewed, the scan becomes a permanent part of your medical file, enabling your doctor to make important comparisons should potential vision threatening conditions show themselves at a future examination. Our doctors believe that the Optomap® Retinal Exam is an essential part of your comprehensive eye exam and offer it to all patients every year.

This imaging device allows the doctor to detect retinal abnormalities, glaucoma, macular degeneration as well as other health conditions such as diabetes, high blood pressure, cholesterol, tumors, and other life-threatening diseases.

Our Doctors Recommend Optomap for the Following Reasons:

- The ability to show you your retinal images today, during your exam
- An in-depth view of nearly the entire retina (where diseases can start).
- A permanent record for your medical records, which gives your doctor a comparison for diagnosing and tracking retinal eye disease annually.

Optomap Retinal Imaging is:

- Fast, easy, comfortable, and patient friendly.
- Eliminates the need to be dilated (in most cases); New patients will be expected to be dilated.

*Please Note: The Optomap® Retinal Screening Exam is not covered under your basic health plan, meaning that you are responsible for the charges. Our fee for the retinal screening, measurement and interpretation is \$35.00. We will collect this fee along with your co-payment and deductibles at the end of your visit.

- Please select one: *

- I elect to have an Optomap Digital Retinal Image of my retina.
- I do not want an Optomap Retinal Image; I am willing to be dilated.

Signature: _____

Date: _____