Previous Patient Health History Form

Name ______________________________ Date of Birth ________________ M or F

Address ____________________ City: ______________ State ______ Zip ________

Phone # ________________ Secondary Phone # ________________

Email: ________________ Preferred Language: ________________

Vision Insurance ________________ Primary on Vision Insurance ________________

Vision Insurance # or ID ____________ Health Insurance ________________

Last Medical Exam ____________

Any changes to overall health? (list) ________________________________

Medications (list)________________________________

Allergies to medicine (list) ________________________________

Any changes to ocular health? (list) ________________________________

Do you wear glasses? ◯Yes ◯No

Do you wear contact lenses? ◯Yes ◯No Type: ________________________

Are you interested in a contact lens fit today? ◯Yes ◯No

I. Informed Consent for Dilated Fundus Exam

Pupil dilation is recommended every 2 years to thoroughly evaluate internal eye health. Dilation is recommended at least every year for diabetic patients and those with ocular conditions that need to be monitored. Without dilation, serious eye diseases may go unseen, which include but are not limited to, ocular diabetic complications, retinal detachment, tumors and hypertensive vessel changes. *Such conditions can lead to vision loss, blindness or even death. There is no alternative* procedure that can replace a dilated fundus exam. By signing below, you agree to indemnify, hold harmless, waive and release from any and all claims or legal actions that may arise as a failure to comply with the instructions and recommendations regarding dilation. I also understand that if my medical history warrants dilation, my doctor has the authority to insist on the procedure in order to continue with the examination.

Please check one: ◯ I agree to dilation today. ◯ I refuse dilation today.
◯ I will be responsible for rescheduling my dilation.

Patient/Guardian signature: ________________________ Date :____________