**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**

1. **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.

1. **OPTOS Retinal Imaging**

Retinal imaging is a recommended procedure to help the doctor attain a wider view of the retina and posterior eye structures. This can be done without dilation, but does not replace a dilated eye exam. Retinal images are kept on file and act as a permanent photographic record that will aid in the monitoring of hypertension, ocular diabetic changes, macular degeneration and other eye abnormalities. Optos uses very bright green lights that can exacerbate symptoms of epilepsy. If you would like to have retinal imaging done please check the box below.

⃝ I agree to OPTOS retinal imaging and I agree to pay the $29.00 copay for the procedure.

⃝ I do not want OPTOS retinal imaging at this time.

Patient/Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_