



Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

1. Would you like to make any changes to your HIPAA release of information?

Yes No If yes, describe: \_\_\_\_\_

2. Would you like to make any changes to your Assignment of Benefits (insurance information)?

Yes No If yes, describe: \_\_\_\_\_

3. Do you want to be checked for an updated prescription for glasses/contact lenses?

**\*\*\* If you DO NOT have a Vision Insurance, a \$20 fee will be charged for this service.**

**This fee MUST be paid BEFORE the prescription will be finalized by the doctor. \*\*\***

(Medical Insurances DO NOT cover this fee)

Yes No

**Current Medications & Eye Drops:**

(vitamins, birth control, OTC, eye drops)

**Medication / Eye Drop      Dose / Frequency**

Medication / Eye Drop	Dose / Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Medication Allergies:**

\_\_\_\_\_  
\_\_\_\_\_

**Eye Symptoms / History:**

- Blurry Vision
- Cataracts
- Crossed Eye / Eye Turn
- Double Vision
- Eye Burning
- Floaters / Spots
- Glaucoma
- Headaches
- Itchiness
- Macular Degeneration
- Dryness
- Retinal Detachment
- Watering
- Trouble Seeing at Night

Other: \_\_\_\_\_

**Have You Been Diagnosed With:**

- Acid Reflux
- Allergies / Sinus
- Alzheimer's / Dementia
- Arthritis
- Asthma
- Blood / Lymph
- Cancer
- Cholesterol
- Crohn's / IBS
- COPD / Emphysema
- Depression / Anxiety
- Diabetes
- Eczema / Rashes
- Epilepsy
- Fibromyalgia
- Heart Attack
- Heart Disease
- High Blood Pressure
- Lupus
- MS
- Parkinson's
- Stroke
- Thyroid

Other: \_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## Optos Retinal Imaging Information

Our Optomap technology gives your eye doctor a comprehensive view of your retina, which helps in spotting signs of diseases at their earliest stages. By viewing most of the retina at once, your eye doctor can spend more time explaining the images and discussing your eye health with you.

Optomap is recognized in numerous clinical studies as a valuable diagnostic tool. Starting January 1, 2024, we will include this technology in our regular exams as a part of our commitment to high-quality care. We take yearly photos to assist your doctor in monitoring your retinal health and to keep a digital record for future comparison.

THIS TEST IS NOT COVERED BY INSURANCE

Service Fee: \$25.00

YES, I would like to receive this service.

NO, I would NOT like to receive this service

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# Lifestyle Index

PT INITIALS / ID \_\_\_\_\_

DATE \_\_\_\_\_

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — whether it's caused by your eyes, posture, stress, etc. Your responses will help make sure you receive the best care possible.

**How often do you experience any of these symptoms? Fill in applicable circle. For example:** 1 2 3 4 5



## Headaches

of any severity each week, usually getting worse later in the day

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Stiffness / pain in neck / shoulders

when you work at a computer or read

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Discomfort with Computer Use

in your eyes (redness, burning) after long hours looking at the screen

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Tired Eyes

with increasing feeling of eye fatigue throughout the day

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Dry Eye Sensation

feeling progressively more gritty/sandy while working at computer or reading

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Light Sensitivity

especially with brighter, stronger lights like fluorescents or headlights

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



## Motion Sickness

or an experience like dizziness or vertigo

1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### FOR OFFICE USE

Neurolens Value

Prism Split for Order Entry

Misalignment

Mono PD

MQI

AC/A Ratio

OD:

Near:

OD:

Near:

OS:

Distance:

OS:

Distance: