Medical History

Last eye-exam date _____ By Whom _____ In the City,State of _____

Do you or your immediate family have any of the following:

Self	Family		Self	Family		Self	Family	
❑	❑	Allergy	❑	❑	Nervous system	❑	❑	Lazy Eye / Eye turn
❑	❑	High Cholesterol	❑	❑	Skin	❑	❑	Cataract
❑	❑	Diabetes	❑	❑	Ear/Nose/Throat	❑	❑	Macular Degeneration
❑	❑	High Blood Pressure	❑	❑	Blood/Lymph	❑	❑	Glaucoma
❑	❑	Migraines	❑	❑	Respiratory	❑	❑	Blindness
❑	❑	Thyroid condition	❑	❑	Gastrointestinal	❑	❑	Eye Surgery what type? _____
❑	❑	Kidney problem	❑	❑	Heart Trouble			
❑	❑	Arthritis				❑	❑	Eye Injury what type? _____

Do you:

❑ Smoke? How much? _____ ❑ Drink alcohol? How much? _____ ❑ Currently Pregnant? At ____ week(s)

❑ Current Medication ❑ Allergic Medication /substance(s)

_____ _____

Tell us about your Lifestyle :

❑ Reading ❑ Driving ❑Computer : __ hr/ day ❑ Sport what type?_____

***Do you wear contacts?*: ❑ Soft ❑Hard ❑ Ortho-K ❑ Color Brand?_____**

Do you have any UV-blocking eyewear? **❑ Yes ❑ No**

Are you here for:

❑ eyeglasses ❑ contact lenses ❑ both ❑ something else?

What else can we help you today?

❑ Blurry ❑ Glare ❑ Double ❑ Flashes ❑ Floater ❑ Red

❑ Dry eye ❑ Pain ❑ Watery ❑ Burning ❑ Itchy

Are you i*nterested in knowing more about*:

❑ Computer glasses ❑ Contact lens ❑ Ortho-K ❑ Sports goggle ❑ Low-Vision ❑ LASIK

If you're having an eye examination with contact lenses, evaluation fee starting at $50 and up will be collected in additional to eye examination without contact lenses.
(This will include evaluation and follow-up within 3 month from the initial exam date. Fees vary dependent upon fitting complexity.)

Yes No, I declined today

Retinal Imaging test allows our doctor to digitally record internal structure of the eyes. The picture monitors changes in optic nerve, retinal blood vessels and macula associated with glaucoma, high blood pressure, diabetes conditions. I agreed to the additional $45 charge.

Yes No, I declined today

It may be necessary to have my eyes dilated today during the course of the examination. Possible side effects are blurriness & sensitivity to light. I herby waive and relinquish any claim for damages against Spectrum Optometry and its doctors for such aforementioned dilation application. If I decline this procedure during today's visit, I understand that a separate fee at a later date.

Yes No, I declined today

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Signature Date