

Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

**EYE**

**DILATION:**

The eye dilation process requires drops instilled in the eyes to enlarge the pupils and allow a wider area to be viewed within the eyes. The side effects include blurry vision and light sensitivity lasting approximately 4-6 hours. This beneficial test exposes subtle changes in the eyes, including retinal detachments, tumors, circulatory conditions (high blood pressure and diabetes), or other eye health problems. I understand that if I choose not to have this test, there exists the possibility of risks that may irreversibly harm my vision or eyes, if left undetected.

\_\_\_\_\_ I consent to having this test if deemed necessary today.

**Personal History**

What is your Occupation?: \_\_\_\_\_

Main Reason for Visit: \_\_\_\_\_

Do you wear : Glasses \_\_\_\_\_ Contact Lenses \_\_\_\_\_ How often do you use a computer \_\_\_\_\_

List any activities which may have specific visual requirements \_\_\_\_\_

Have you ever had : Eye Injury \_\_\_\_\_ Eye Surgery \_\_\_\_\_ Eye Disease \_\_\_\_\_

**Do you or does a Blood Relative have a history of any of the following conditions? ( Circle Yes or No )**

	Self	Relative (specify)
Yes No Diabetes _____		
Yes No High Blood Pressure _____		
Yes No Thyroid _____		
Yes No Allergies _____		

	Self	Relative (Specify)
Yes No Glaucoma _____		
Yes No Heart Disease _____		
Yes No Blindness _____		
Yes No Reaction to any Medication _____		

Please List Any Medications you are taking \_\_\_\_\_  
 \_\_\_\_\_

**Please see Patient Information Privacy Notice**