PATIENT INFORMATION

Last Name _____ First _____ Date_____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Email address _____

Phone Numbers: Home _____ Work _____ Cell _____

Parent's Name (if under 18)_____ Spouse's Name (if married) _____

Occupation or Grade (if student) _____ Employer _____

How did you hear about us? _____ School (if student) _____

Approximate date of last exam _____ Previous Eye Doctor _____

Are you presently wearing glasses? _____ If not, have you ever worn glasses?_____

Are you currently wearing contacts? _____ Do you sleep in contacts?_____ If so, how long?_____

Type of contacts worn? ___ Soft Lenses ___ Daily Wear ___ Disposable
___ Hard or Gas Permeable ___ Extended Wear ___ Frequent Replacement

What are your reasons for visiting our office today? (Check all appropriate items)

___ General check-up
___ Lost or broken glasses
___ Want new glasses
___ Blurred distance vision
___ without glasses
___ with current glasses
___ Blurred near vision
___ without glasses
___ with current glasses
___ See spots or floaters
___ See flashing lights
___ Temporary vision loss

___ Eyes water
___ Eyes burn
___ Eyes red
___ Eyes feel dry
___ Eyes itch
___ Eyes mattering
___ Headaches
___ Eyestrain
___ Pain in eyes
___ Double vision
___ Light sensitive
___ Glare

___ Problems with current contact lenses
___ Want a new type of contacts
___ Soft Contacts or ___ Hard or Gas Perm Contacts
___ Daily Wear or ___ Extended Wear
___ Disposable or ___ Frequent Replacement
___ Want an updated prescription for the exact same type of contacts currently being worn.
___ Other (please list) :

_____

_____

Your general and ocular health (past or present). Check all that apply.

___ High blood pressure	___ Diabetes	___ Blindness	___ Cataracts
___ Heart problems	___ Allergies	___ Glaucoma	___ Eye turn
___ Respiratory problems	___ Asthma	___ Lazy eye	___ Poor color vision
___ Multiple sclerosis	___ Migraine headaches	___ Retinal disorder	___ Currently pregnant
___ Thyroid condition	___ Arthritis	___ Cancer	___ HIV positive

List any other visual and/or health conditions not listed above _____

_____

List any eye injuries, diseases, or surgeries you have had _____

_____

Has any family member had any of the above conditions? Please list relative and condition. _____

_____

List medications you are currently taking _____

Do you have any allergies to medications? _____

List any insurance or health care plan you have which will pay toward your eyecare _____

Method of payment: ___ Cash ___ Check ___ MC/Visa ___ American Express ___ Discover Other _____

Signature_____

We are committed to providing quality eyecare to our patients by using the most advanced equipment and techniques. The following tests can often identify changes at early stages before they become significant problems. We strongly recommend that our patients receive the following tests as part of their comprehensive eye examination.

DILATION OF THE EYES

In order to more thoroughly examine the inside of the eye for diseases such as glaucoma, cataracts, tumors, and retinal degenerations it is best to dilate (enlarge) your pupils. After the initial examination, 2-3 drops will be instilled in each eye. It then takes an additional 20-30 minutes for your pupils to dilate. Your pupils will gradually return to their normal size over a period of 4-6 hours. During that time you will be sensitive to bright lights and reading and other close work, including computer work, will be difficult. We will provide free, disposable sun shields if needed for light sensitivity. Most people are comfortable driving, however, if you do not feel comfortable with your vision after dilation, please call someone to pick you up or bring someone to drive you home. If dilation should be contraindicated in your case, the doctor will inform you.

We realize that not every patient's schedule will allow him or her to undergo this procedure. However, we feel that the benefits outweigh the disadvantages and recommend that our patients have their eyes dilated when possible.
You may return to have your eyes dilated at a later date if you choose. There will be no additional charge as long as you do so within 30 days of today's examination date.

There may be some instances in which we may not be able to dilate your eyes the same day as your examination due to scheduling, an emergency, or other unforeseen circumstances.

Do you want your eyes dilated today? ___ Yes ___ No

VISUAL FIELD SCREENING

Most major causes of blindness in the United States can often be detected by changes in the visual field. A highly sophisticated computerized instrument now enables us to provide a visual field screening in less time and at much less cost. This instrument checks for areas of reduced vision in the central (straight-ahead) and peripheral (side vision) areas. Visual field testing is important in the early diagnosis of glaucoma, retinal problems, and some neurological diseases such as brain tumors and optic nerve disease. Unfortunately, an individual does not notice most visual field defects until very late stages. Early detection significantly increases the chances of either curing the disorder or at least minimizing its effects.

There is an additional fee of $10.00 for the visual field screening.

Do you want to have the visual field screening performed? ___ Yes ___ No

If you chose not to have one or both of the above tests performed, please sign the liability release below:

Liability Release: I have been informed by the office of Kevin Gajda, O.D. and his associate optometrists of the importance of pupil dilation and visual field screening. I have chosen not to have one or both of these tests performed, and I will not hold the office of Kevin Gajda, O.D., his associates, and/or his staff responsible for any disease or pathology (or its effects) that goes undetected due to the lack of diagnostic information that could have been obtained by these testing procedures.

Name (Please print): _____

Signature: _____ Date: _____