PATIENT HEALTH HISTORY

(with Optomap)

Date: _____

Patient Name (Print): _____ DOB_____/_____/_____ Email: _____

Address: _____ City:_____ State: _____ Zip: _____ Phone Number:_____

Primary Care Physician: _____ Occupation: _____ Gender: M / F

Due to current Federal Medical Guidelines, we are required to obtain the following information

Preferred Language: English / Spanish **Preferred Communication Preference**: Email / Postal Mail / Telephone
Race: Black/African American, American Indian/Alaska Native, Hispanic, Asian, White, Native Hawaiian/Other Pacific Islander
Ethnicity: Hispanic/Latino, Native Hawaiian/Other Pacific Islander, Not Hispanic or Latino

What is the main reason for your visit today? _____ **Do you wear?** Contacts / Eyeglasses **Are you interested in contacts?** Y / N

Medical/Family History

Please list current medications:_____

_____

List any allergic reactions to **medications or eye drops**: _____

_____

Women – Are you pregnant? Y / N

Please indicate if any of the conditions apply:

Disease/Condition	Yourself Yes	Yourself No		Family Member Yes	Family Member No	Relationship (Blood Relatives Only)
Cataract	☐	☐	Blindness	☐	☐	_____
Eye Turn	☐	☐	Eye Turn	☐	☐	_____
Glaucoma	☐	☐	Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	Retinal Detachment	☐	☐	_____
Eye Surgery	☐	☐				
Eye Injury	☐	☐				

Other:_____

Are you diabetic? Y/N If so, what year were you diagnosed? _____ What was your blood sugar today? _____
What is your most current HbA1C? _____

Review of Systems Please indicate below (circle) if you have any of the following conditions:

Social Tobacco Use: Current Smoker / Former Smoker / Non-Smoker Non-prescription drugs Alcohol Consumption

Allergic/Immunologic
- Lupus (SLE)
- Rheumatoid Arthritis
- Environmental Allergies
- Seasonal Allergies
- Other (i.e., Latex)

Ear, Nose and Throat
- Sinusitis
- Upper Respiratory Tract Infection
- Other

Gastrointestinal
- Crohn's Disease
- Colitis
- Acid Reflux/Ulcer
- Other

Skin/Integumentary
- Eczema
- Rosacea
- Psoriasis
- Other

Psychiatric
- Depression
- Bi-Polar
- Schizophrenia
- Other

Cardiovascular
- High Blood Pressure
- Heart Disease
- Stroke
- Vascular Disease
- High Blood Cholesterol

Endocrine/Glands
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction
- Other

Respiratory
- Asthma
- Bronchitis
- Emphysema
- Other

Muscle/Skeletal
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Other

Genital/Urinary
- Urinary Tract Infection
- HIV Positive
- Herpes/Chlamydia
- Other

Hematologic/Lymphatic
- Anemia
- Leukemia
- Bleeding Disorder
- Other

Neurological
- Multiple Sclerosis
- Epilepsy
- Tremors
- Other

General Health
- Weight loss/gain
- Fever
- Fatigue
- Trauma

Lifestyle Information: To help us assist you with your eye care needs, please circle all that apply:

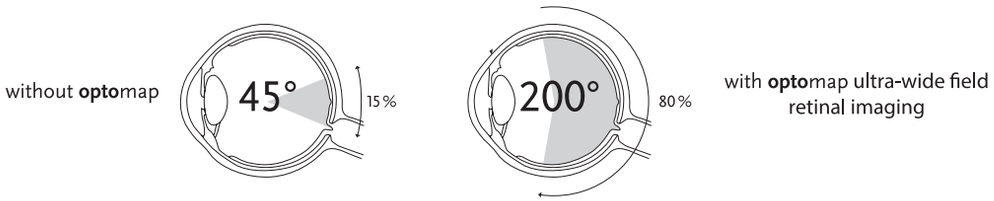
Boating/Fishing Computer use (give % of time each day _____) Shooting Golfing Motorcycling Bicycling
Participate in Sports Swimming Driving Hunting Close-up work Woodworking Use of Power Tools
Intermediate Work Gardening Reading Hiking Other:_____

Optomap Digital Retinal Imaging & Visual Field Screening

- The Optomap retinal exam is a non-invasive digital image which allows the Doctor to see a much more detailed view of the retina. These images become a permanent part of you medical file, giving the Doctor the ability to compare images year after year for any subtle or major changes. In many cases, dilation will not be necessary if Optomap is done.
- Our visual field analyzer allows us to provide a more thorough medical analysis of your eyes. The visual analyzer electronically measures peripheral retinal function. Areas which can not be detected through the comprehensive exam.

***Optomap and the visual field screening both can assist in early detection of many disorders, including diabetes, high blood pressure, high cholesterol, age-related macular degeneration, retinal detachments, glaucoma, and brain tumors.

OUR DOCTORS STRONGLY RECOMMEND EVERY PATIENT RECEIVE THE OPTOMAP AND VISUAL FIELD SCREENING EACH YEAR DURING THEIR ANNUAL VISIT.



____ YES, I would like the Optomap digital imaging & Visual Fields Screening. - $50
____ YES, I would like the Optomap digital imaging only. - $40
____ YES, I would like the Visual Fields Screening only (possible dilation, too). - $15
____ NOT SURE. I need more information from the Doctor.

Patient Signature:_____ Date: _____

Insurance Information: Are you covered by vision coverage? Y/N If yes, please list: _____

SSN/Insurance #: _____ Do you have secondary vision coverage? _____

We will make every effort to check your eligibility with your insurance carrier. Because of the ever-changing information with insurance companies and/or circumstances beyond our control, WE CANNOT GUARANTEE THAT YOUR VISION BENEFITS WILL ALWAYS COVER PART OR ALL OF YOUR PURCHASES FROM US. You will be responsible for any unpaid balance. If you have any concerns regarding your insurance benefits and eligibility, we urge you to contact your insurance carrier before you order products or services from us.

Servicing and Collections

If we need to contact you to service your account or to collect amounts you owe, you authorize us (and our affiliates, agents and contractors) to contact you at any number you provide, from which you call us, or at which we believe we can reach you. We may contact you in any way, such as calling, texting or emailing. We may contact you using an automated dialer or pre-recorded messages. We may contact you on a mobile, wireless or similar device, even if you are charged for it. If your account goes into collections, you will be required to pay the full balance of your account and an additional $36 collection fee.

Marketing Communications

We may communicate with you via email, electronic or print newsletter, electronic or print surveys, social media platforms (e.g., Facebook, Instagram, Twitter, YouTube, Pinterest, Linkedin, Pinterest) or by postcard.

Please sign to acknowledge the information on this form is current, for insurance billing (if applicable), servicing and collection policies and for receiving a copy of our Notice of Privacy Practices.

Patient's Signature or legal guardian : _____ Date: _____

Initials: _____

FOR OFFICE USE:

Eyeglasses 1: Date :_____

OD_____ Add: _____

OS _____ Add: _____

Transitions/Polarized/Anti-Reflective/Teflon AR/ Tint

Contact Lenses:

Brand: _____ OD_____

BC: _____ OS _____

Additional Notes:

_____

_____

Wisconsin Vision Heartland Vision EYE BOUTIQUE