Hillcrest Vision OD PA

First Name_____ **MI**_____ **Last Name** _____

Date of Birth_____ **Social Security Number**_____

Gender: □ Male □ Female **Marital Status:** □ Married □ Single □ Divorced □ Widowed

Race: □ American Indian □ Asian □ Black or African American □ Pacific Islander □ White or Caucasian

Street Address_____ **City**_____ **State**_____ **Zip Code**_____

Home Phone_____ **Cell Phone** _____

Work Phone_____ **Email Address** _____

How would you like to be contacted? □Home Phone □Cell Phone □Work Phone □Text □Email

Employment Status □Unemployed □ Employed □ Retired □ Disabled □Student

Employer/School_____ **Occupation** _____

Emergency Contact _____ **Relationship** _____ **Phone** _____

Who can we thank for referring you? _____

Person Responsible for Payment _____

Please list persons with whom we may discuss your health/account information:

_____ _____ _____

Do you currently have or have ever had the following conditions? Check those that apply.

□ **ADHD**	□ **Depression**	□ **High Blood Pressure**	□ **Multiple Sclerosis**
□ **Anxiety**	□ **Diabetes**	□ **High Cholesterol**	□ **Retinal Detachment**
□ **Autism**	□ **Glaucoma**	□ **Hyperthyroidism**	□ **Rheumatoid Arthritis**
□ **Cancer**	□ **Headaches**	□ **Hypothyroidism**	□ **Sjogrens**
□ **Cataracts**	□ **Head Trauma**	□ **Macular Degeneration**	□ **Stroke**

Medications: _____

Allergies: _____

Surgeries: _____

List any other medical conditions: _____

<u>Family History</u>

Does any family member (parents, grandparents, siblings, and children) currently have or had any of the following conditions? If yes, please write the relationship to you next to the condition.

□ **Blindness**	_____	□ **Glaucoma**	_____
□ **Cataract**	_____	□ **Macular Degeneration**	_____
□ **Retinal Disease**	_____	□ **Diabetes**	_____

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What problems or concerns would you like addressed at this visit?

_____

How many hours a day do you spend on electronic devices? (Computer/phone/tablet) _____

Do you wear prescription glasses?	YES	NO	
Are you interested in purchasing glasses today?	YES	NO	MAYBE
Do you wear contacts?	YES	NO	
Are you planning on getting a contact lens evaluation today?	YES	NO	

iWellness Imaging Consent

The iWellness scan is a quick, non-invasive scan that allows Dr. Hall and Dr. McAllister to see beneath the surface of your retina. This unique technology can help our doctors detect vision threatening and systemic diseases in their very early stages, when they are most treatable. Vision threatening diseases such as glaucoma, macular degeneration, and diabetic retinopathy often have no signs or symptoms in the early stages. Our doctors recommend that ALL patients have this procedure performed, and it is especially important for people who have a personal or a family history of glaucoma, macular degeneration, or other eye diseases. It is painless and there are no side effects or light sensitivity. Any questions that you may have about your iWellness scan and the results of the scan, can be discussed with the doctor during your examination. The scan is part of your medical record and can be compared with future scans, allowing us to observe even the smallest amount of change. **There is a $39 charge for this test and it is not covered by your vision plan or medical insurance.** Thank you for choosing our practice to protect the health of your eyes!

_____ (Initial here) Yes, I want to have the iWellness imaging performed.

_____ (Initial here) No, I do not wish to have the iWellness imaging performed.

Ocular Surface Discomfort is the most frequent reason that patients visit eye doctors. Therefore, we ask that you take a few moments and thoughtfully complete the questionnaire below.

Report the FREQUENCY of symptoms you are experiencing:

Symptoms	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0= Never 1= Sometimes 2= Often 3= Constant

Report the SEVERITY of your symptoms using the ratings list below:

Symptoms	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0= No problems
1= Tolerable (not perfect but not uncomfortable)
2= Uncomfortable (irritating but does not interfere with my day)
3= Bothersome (irritating and interferes with my day)
4= Intolerable (unable to perform my daily tasks)

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