



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

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to specify

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 Student Military

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.

- | | | | |
|------------------------------------|--------------------------------------|---|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Sjogrens |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Stroke |

Medications: _____

Allergies: _____

Surgeries: _____

List any other medical conditions: _____

Family History

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.

- | | |
|--|---|
| <input type="checkbox"/> Blindness _____ | <input type="checkbox"/> Glaucoma _____ |
| <input type="checkbox"/> Cataract _____ | <input type="checkbox"/> Macular Degeneration _____ |
| <input type="checkbox"/> Retinal Disease _____ | <input type="checkbox"/> Diabetes _____ |



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 the doctor 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)

