Patient Demographics/ Medical History

Full Name: _____ **Birth Date:** _____/_____/_____

Address:_____ **SSN:** _____

Occupation: _____ **Cell Phone:**_____

Employer: _____ **Work Phone:** _____

Email Address: _____

Medical Doctor: _____

Primary Card Holder Name/DOB/SSN: _____/_____/_____

Responsible Party if different: _____ **Relationship to Patient:** _____

Phone: _____ **Billing Address if different:** _____

How may we contact you for appointment reminders? (Circle all that apply): email cell home text mail

Please check the box beside any problem you currently have, or have had, in the following area

CONSTITUTIONAL
- ☐ Fever
- ☐ Weight Loss/Gain
- ☐ All normal

EARS, NOSE, MOUTH, THROAT
- ☐ Sinus Congestion
- ☐ Dry Throat/Mouth
- ☐ All normal

NEUROLOGICAL
- ☐ Migraines
- ☐ Dizziness
- ☐ Seizures
- ☐ Stroke
- ☐ All normal

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss
- ☐ Hallucinations
- ☐ All normal

CARDIOVASCULAR / CARDIAC
- ☐ Arteriosclerosis
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ All normal

RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ All normal

GASTROINTESTINAL
- ☐ Diarrhea/Constipation
- ☐ Ulcers
- ☐ Reflux
- ☐ IBS/Crohn's Disease
- □ All normal

GENITOURINARY
- ☐ Kidney Disease
- ☐ Ovarian / Uterine Cancer
- ☐ Prostate Cancer
- □ All normal

MUSCULOSKELETAL
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain
- □ All normal

INTEGUMENTARY (Skin)
- ☐ Cancer
- ☐ Rashes
- ☐ Easy Bruising
- □ All normal

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Chronic Fatigue
- □ All normal

HEMATOLOGIC / LYMPHATIC
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Breast Cancer
- □ All normal

ALLERGIC / IMMUNOLOGIC
- ☐ Allergy / Hay Fever
- □ All normal

List any medications you are currently taking (including oral contraceptives, aspirin, over the counter medications):

_____

_____

Are you allergic to any medications? ☐ No □ Yes **If yes, which ones?**

_____

List all major surgeries and/or hospitalizations you have had:

_____

Do you smoke or use smokeless tobacco?_____**How much/day?**_____

Do you drink alcohol?_____**How much?**_____

Do you use recreational drugs? _____

Height:_____**Weight:**_____

FAMILY HISTORY Please note family history (parents, grandparents, siblings, children; living or deceased) :

	RELATION TO YOU		RELATION TO YOU
☐ Cancer	_____	☐ Cataract	_____
☐ Diabetes Type I	_____	☐ Macular Degeneration	_____
☐ Diabetes Type II	_____	☐ Glaucoma	_____
☐ Hypertension	_____	☐ Heart Disease	_____
☐ Hyperthyroidism	_____	☐ Hypothyroidism	_____

DILATION CONSENT AND RETINAL SCREENING PHOTOGRAPHY

We are excited to announce that we have incorporated into our practice a new, highly sophisticated, computerized instrument that allows us to provide a more thorough medical analysis of your eyes. This procedure is now being recognized as the new standard of care. The procedure assists the doctor in the early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and other vision threatening conditions. This machine can often detect problems that cannot be seen by the naked eye during eye examinations. This testing allows the doctor to observe even the smallest change from the previous exam.

We strongly recommend this procedure as part of your exam if:

- Your are a new patient to this office
- You have never had retinal photos of your eyes
- You are 65 or older
- You have or have a family history of high cholesterol, elevated blood pressure, diabetes, glaucoma, or elevated eye pressure.
- You have headaches or visual disturbances suggestive of a neurological problem, any retinal disorder such as a detachment, tear, floaters, veils, flashing lights, bleeding, or macular degeneration
- Your vision is not correctable to 20/20 in one or both eyes

"Screening Retinal Photography" is a necessary part of your eye examination if you fall into any of the above categories. The charge for this procedure is $35.00 and unfortunately is not covered by insurance at this time. If pathology or an "at risk" condition is documented with the screening photos, additional in depth photos may be recommended, but should be covered by your insurance. **This testing does not eliminate the need for dilated fundus examinations.**

Dilation is an important part of a complete eye examination. Dilation will make your pupil large so that Dr. Atchison can get a better look at the back of the eye to check for any problems. The dilation will make reading things up close difficult, and make lights seem brighter than usual. This will last for 3-5 hours, although it can lost longer in some people. Most people will be able to drive once their eyes are dilated. However, if you feel uncomfortable driving, or have never driven with your eyes dilated, it may be best to have a driver. Please know there is no additional charge for having your eyes dilated.

Please check one of the following:

Dilation: ○ ***Yes*** ○ ***No***

Retinal Screening Photography ($35.00): ○ ***Yes*** ○ ***No***

In refusing to have my eyes dilated, or Retinal Screening Photography done today, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have been provided by this test.

Patient/Gaurdian: _____ **Date:** _____