Burnt Hills Optical

Last Name_____ First Name_____ MI____ Date of Birth: _____

Family History

Is there any family medical history of any of the following? (**If yes please list the relationship to you**)

Cataracts	□Yes □No _____	Diabetes	□Yes □No _____
Glaucoma	□Yes □No _____	High Blood Pressure	□Yes □No _____
Lazy Eye	□Yes □No _____	Retinal Detachment	□Yes □No _____
Macular Degeneration	□Yes □No _____	Color Blindness or other	□Yes □No _____

Patient Eye History

Have you ever been diagnosed or treated for the following?		**Do you experience any of the following?**			
Cataracts	□ Yes □ No	Headaches	□ Yes	□ No	□ Sometimes
Glaucoma	□ Yes □ No	Double Vision	□ Yes	□ No	□ Sometimes
Macular Degeneration	□ Yes □ No	Persistent Floaters	□ Yes	□ No	□ Sometimes
Retinal Detachment	□ Yes □ No	Flashes of Light	□ Yes	□ No	□ Sometimes
Lazy eye or Eye turn	□ Yes □ No	Eye Itching	□ Yes	□ No	□ Sometimes
Eye Injury	□ Yes □ No	Eye Tearing	□ Yes	□ No	□ Sometimes
Eye Surgery	□ Yes □ No	Eye Burning	□ Yes	□ No	□ Sometimes
Blurry Vision	□ Yes □ No	Other: _____			

Have you ever been diagnosed or treated for any of the following conditions?		**Explanation of Condition**
Endocrine- thyroid, hormones, glands	□ Yes □ No	_____
Cardiovascular – heart, blood vessels	□ Yes □ No	_____
High Blood Pressure	□ Yes □ No	_____
Respiratory- lungs, breathing	□ Yes □ No	_____
Gastrointestinal- stomach/ intestines	□ Yes □ No	_____
Genitourinary- genitals, kidneys, bladder	□ Yes □ No	_____
Musculoskeletal- muscles, joints, arthritis	□ Yes □ No	_____
Skin or other Integument Condition	□ Yes □ No	_____
Neurological- migraine, seizures	□ Yes □ No	_____
Psychiatric	□ Yes □ No	_____
Ears, Nose, Mouth or Throat	□ Yes □ No	_____
Hematologic/Lymphatic- anemia, bleeding	□ Yes □ No	_____
Allergic/ Immunologic	□ Yes □ No	_____
HIV/AIDS	□ Yes □ No	_____
Cancer	□ Yes □ No	_____

Do you have Diabetes? □Yes □No What year were you diagnosed? ___Type 1□ or 2□ What was your last HbA1c? _____
Do you drink alcoholic beverages? □ Yes □ No □ Sometimes
Are you currently Pregnant or Nursing? □ Yes □ No

Authorization to pay benefits to physician.

I hereby authorize payment of benefits directly to the doctor for services received. I understand that I am responsible for the balance of fees not paid by the insurance.

Please sign below that you have reviewed all of the information above and it is correct to the best of your knowledge.

Signature_____ ***Date***_____

Please bring a list of all your current medications to your appointment

Last Name_____ First Name_____ MI_____

Your Vision Lifestyle

Please check how often you currently wear the following forms of sight correction and/or sight protection.

Glasses	□ Always	□ Often	□ Sometimes	□ Never
Contact lenses	□ Always	□ Often	□ Sometimes	□ Never
Non Prescription Sunglasses	□ Always	□ Often	□ Sometimes	□ Never
Prescription Sunglasses	□ Always	□ Often	□ Sometimes	□ Never
Safety or Sport Eyewear	□ Always	□ Often	□ Sometimes	□ Never

Please check your participation level in the following activities and indicate whether or not use your glasses/contact lenses for that activity.

			I Use eyewear for this activity:	
Reading	□ Frequently	□ Infrequently	□ Yes	□ No
Computer Use	□ Frequently	□ Infrequently	□ Yes	□ No
Television	□ Frequently	□ Infrequently	□ Yes	□ No
Driving	□ Frequently	□ Infrequently	□ Yes	□ No
Sports (please specify_____)	□ Frequently	□ Infrequently	□ Yes	□ No
Other: _____	□ Frequently	□ Infrequently	□ Yes	□ No

Do you currently experience any of the following problems with your current eyewear?

Too Heavy	□ Always	□ Often	□ Sometimes	□ Never
Poor fit or wrong size	□ Always	□ Often	□ Sometimes	□ Never
Difficulty with bifocal	□ Always	□ Often	□ Sometimes	□ Never
Too much glare	□ Always	□ Often	□ Sometimes	□ Never
Need for constant adjustment	□ Always	□ Often	□ Sometimes	□ Never

Do You:

Spend a lot of time outdoors	□ Yes	□ No
Currently have prescription sunwear	□ Yes	□ No
Want information on laser vision correction	□ Yes	□ No
Currently have computer eyewear	□ Yes	□ No
Wear bifocals	□ Yes	□ No
Think you would benefit from thinner, lighter lenses	□ Yes	□ No
Have an interest in "no line" bifocals/progressive lens	□ Yes	□ No
Have an interest in transitions/photochromatic lenses	□ Yes	□ No
Have an interest in being fit for contact lenses	□ Yes	□ No

Do you have any other visual needs you would like us to address? □ Yes □ No

If so, please explain:

_____

_____

_____

Burnt Hills Optical

A visual field examination determines to what degree you are able to see peripheral objects while fixated on a stationary object. It electronically measures retinal function. This measurement can assist in the early detection of many disorders; including glaucoma, brain tumors, diabetic retinopathy, retinal detachments, hypertensive retinopathy, and many other conditions which can manifest itself in the eye.

Using the Visual Field Instrument, we are now able to provide a more thorough medical analysis of your eyes, not able to be provided through a routine eye examination. Our Humphrey FDT electronically measures retinal function and sensitivity to light, to aid in the diagnosis of those very serious diseases. There is currently no better method of early detection and therefore early treatment.

We strongly recommend that all our patients receive the screening version of this test. It is especially important for people who:

- Experience frequent **headaches**
- Have a history of **glaucoma**
- Are a **stroke** candidate and/or had a stroke
- See spots or flashes of light
- Have a history of **diabetes**
- Have a history of **high blood pressure**
- Require a strong eyeglass prescription
- Require frequent change in their prescription
- Are 35 years of age or older

There is an additional charge of $10 for the screening exam. You will be given a receipt for submission to your insurance company.

Please check the appropriate line below and sign at the bottom.

_____ I DO want the Visual Field Exam

_____ I DO NOT want the Visual Field Exam

Patient Signature_____ Date_____