❖

Dr. Bollenbacher & Associates

DOCTORS OF OPTOMETRY

PERSONAL INFORMATION

Today's Date____/____/

Patient Name: _____ **Date of Birth**_____/_____/_____ **M / F** **Age:**____

Address:_____
(street / apt no.) (city) (state) (zip)

Home: (___) ____-_____ **Cell:** (___) ____-_____ **Work:** (___) ____-_____ **email:**_____

Occupation:_____**Employer / School:**_____ **Height:**___ft. ___in. **Approx Weight:**___lbs.

Please circle any that apply: Married / Single / Widowed / White / Black / Asian / Pacific Islander / Hispanic or Latino

Responsible party / parent / guardian (if patient is a child): _____

Responsible party's address / phone #:_____
(street / apt no.) (city) (state) (zip) (phone #)

Whom may we thank for this referral?_____ **Primary Physician?**_____

EYE HEALTH AND VISION QUESTIONNAIRE

What is the main reason for your visit today?_____

Do you have more than one pair of current Rx eyeglasses?	Y	N
Do you use appropriate UV protection for your eyes when outside?	Y	N
Do you have dry eye symptoms (*eg.* eyes that feel scratchy, burning, tired, watery, irritated)?	Y	N
Are you experiencing any flashes of light or floaters in your vision?	Y	N
Are you interested in refractive surgery, including LASIK?	Y	N
Are you interested in a contact lens prescription today?	Y	N

If you are a contact lens wearer, please answer the following questions:

How long do you use each pair of your contacts?_____		
Do you wish that your current lenses were more comfortable?	Y	N
Are you interested in sleeping in your lenses?	Y	N

Please let us know what contact lenses you are currently wearing (if known):

	BRAND	POWER	BASE CURVE	DIAMETER
RIGHT EYE				
LEFT EYE				

HIPAA ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been presented with the Notice of Privacy Policy of Dr. Bollenbacher & Associates and have been offered a copy of such policy to keep for my records.

Signature:_____ **Date:**_____

MEDICAL HISTORY

Please explain if you have had any eye disease or eye injuries (*eg*. glaucoma, cataract, "lazy" eye, retinal detachment, *etc*.):

_____

Please explain previous surgeries or hospitalizations, if any:_____

Please list your current medications (including eye or over the counter medications):_____

_____

Please list any food or drug allergies:_____

Do you smoke tobacco? Y N If YES, how much?_____

Do you drink alcohol? Y N If YES, how much?_____

Do you use any other drugs? Y N If YES, please explain:_____

FAMILY HISTORY **Please note any family history for the following conditions:**

			If YES which family member?
Glaucoma	Y	N	_____
Cataract	Y	N	_____
Macular Degeneration	Y	N	_____
Retinal Disease or Blindness	Y	N	_____
Crossed Eye (Eye turn) or Lazy eye (Amblyopia)	Y	N	_____
Diabetes	Y	N	_____
Other:_____	Y	N	_____

REVIEW OF SYSTEMS **Please note any previous or current medical diagnoses or symptoms:**

			If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue, nausea	Y	N	_____
Cardiovascular (*eg*. heart disease, high blood pressure, stroke, arrhythmia)	Y	N	_____
Ear/nose/throat (*eg*. hearing loss, sinus problems, sore throat)	Y	N	_____
Respiratory (*eg*. shortness of breath, wheezing, coughing)	Y	N	_____
Gastrointestinal (*eg*. ulcer, gastric reflux, hepatits, irritable bowel)	Y	N	_____
Urinary (*eg*. pain or discomfort, blood in urine, STD)	Y	N	_____
Musculoskeletal (*eg*. muscle aches, joint pain, swollen joints)	Y	N	_____
Skin (*eg*. rashes, excessive dryness, cancer)	Y	N	_____
Neurological (*eg*. numbness, weakness, headaches, paralysis)	Y	N	_____
Psychiatric (*eg*. depression, anxiety)	Y	N	_____
Endocrine (*eg*. Type I or II diabetes, thryroid disorder)	Y	N	_____
Blood / Lymph (*eg*. anemia, leukemia, hemophelia, lyme disease, lymphoma)	Y	N	_____
Allergic / Immune (*eg*. shortness of breath, wheezing, coughing)	Y	N	_____

OPTOS OPTOMAP NON-DILATED OPTION

A new, highly sophisticated computerized instrument now allows us to provide a more thorough medical analysis of your ocular health. Our new OPTOS OPTOMAP produces ultra-widefield, high resolution digital images of approximately 82% of the retina, something no other device can do in a single image. It can assist us in the early detection of many disorders including macular degeneration, glaucoma, diabetic retinopathy, and retinal detachments. It also provides a digital reference of retinal and optic nerve abnormalities for future comparison.

We strongly recommend that all of our patients receive OPTOMAP imaging regularly, **especially** those with the following:

1) Glaucoma
2) Headaches
3) Floaters or flashes of light
4) Circulatory problems
5) A strong eyeglass prescription
6) Age 40 and over
7) History of high blood pressure
8) History of diabetes
9) Family history of glaucoma

There is an additional charge of $39 for the OPTOMAP.

Please check the appropriate box below and sign.

□ I DO want the OPTOMAP

□ I DO NOT want the OPTOMAP