Anna Eyecare, PA

OCULAR / MEDICAL HISTORY

(Please Print)

Today's Date:	Patient's Name:

REASON FOR VISIT

Name of Previous Eye Doctor:	Date of Last Eye Exam:

What is Your Chief Complaint? (*Reason for visit*):

Today's Examination is Especially For (*check all that apply*):

☐ Glasses ☐ Contact Lenses ☐ Lasik ☐ Routine Yearly Exam

☐ Eye Infection or Injury (*please explain*)______________________________

☐ Other____

Do you currently wear contact lenses?	☐ Yes ☐ No	If yes, what type/brand?_______________
Are you happy with your contact lenses?	☐ Yes ☐ No	If no, why not?____________________
Do you want to wear contacts?	☐ Yes ☐ No	☐ Clear ☐ Color ☐ Both
Do you wish you could sleep in your lenses?	☐ Yes ☐ No	
Do you currently sleep in your lenses?	☐ Yes ☐ No	

OCULAR HISTORY

Please check yes or no if the patient has any of the following ocular conditions. If an immediate family member has any of these ocular conditions check the box and please indicate who.

	Yes	No	In Family		Yes	No	In Family
Glaucoma	☐	☐	☐__________	Other Eye Diseases	☐	☐	☐__________
Cataract	☐	☐	☐__________	*If yes, please explain*	__________		
"Lazy Eye"	☐	☐	☐__________	Eye Surgery	☐	☐	☐__________
Macular Degeneration	☐	☐	☐__________	*If yes, please explain*	__________		
Retinal Detachment	☐	☐	☐__________	Eye Injury (*explain*)	☐	☐	☐__________

Please check the Eye/Vision symptoms the patient is experiencing:

- ☐ Headaches / Blank Spots in Vision
- ☐ Difficulty When Driving at Night
- ☐ Eyes Feel Scratchy, Gritty, or Sandy
- ☐ Double Vision
- ☐ Frequent Styes
- ☐ Holds Reading too Close
- ☐ Mucous Discharge-Infection of Eye or Lid
- ☐ Loss of Peripheral (side) Vision
- ☐ Curtain or Veil in Vision
- ☐ Distance Vision Blurry
- ☐ Eyes Feel Tired with Near Tasks
- ☐ Eyes Water Excessively
- ☐ Glare or Light Sensitivity
- ☐ Red – Dry – Itching – Burning
- ☐ Must Hold Reading Farther Away
- ☐ Foreign Body Sensation
- ☐ Squinting
- ☐ Near Vision Blurry
- ☐ Drooping Eyelid
- ☐ Eyes Burn with Computer Use
- ☐ Crossed Eye "Lazy Eye"
- ☐ Sudden or Slow Loss, Blurred, Fluctuating
- ☐ Light Flashes / Spots or "Floaters"
- ☐ Other ____________________

Please check your job or hobby activities:

- ☐ Reading
- ☐ Sewing
- ☐ Musical Instrument
- ☐ Golf
- ☐ Racquetball
- ☐ Team Sport
- ☐ Studying
- ☐ Crafts
- ☐ Piano
- ☐ Tennis
- ☐ Scuba Diving
- ☐ Other ____________________________________
- ☐ Computer Use
- ☐ Reading in Bed
- ☐ Card Playing
- ☐ Biking
- ☐ Sky Diving
- ☐ Desk Work
- ☐ Machine Operation
- ☐ TV
- ☐ Swimming
- ☐ Mountain Climbing
- ☐ Drafting
- ☐ Home Workshop
- ☐ Fishing
- ☐ Flying
- ☐ Baseball/Softball

MEDICAL HISTORY

Last Medical Exam:	Results:	Primary Care Physician:

Please check yes or no if the patient has any of the following medical conditions. If an immediate family member has any of these medical conditions check the box and please indicate who.

	Yes	No	Family		Yes	No	Family
Allergies	☐	☐	☐ ____________	Heart Disease	☐	☐	☐ ____________
Arthritis	☐	☐	☐ ____________	High Blood Pressure	☐	☐	☐ ____________
Asthma	☐	☐	☐ ____________	Kidney Problems	☐	☐	☐ ____________
Diabetes	☐	☐	☐ ____________	Nervous System	☐	☐	☐ ____________
Cancer	☐	☐	☐ ____________	Skin Disorder	☐	☐	☐ ____________
Cholesterol	☐	☐	☐ ____________	Thyroid Disorder	☐	☐	☐ ____________

Other ____

List all medications, prescriptions or over the counter, that you're currently taking and the purpose for each:

List any allergies to medications:

Check yes or no if you use any of the following:

	Yes	No	
Tobacco	☐	☐	If yes, how often?____________________
Alcohol	☐	☐	If yes, how often?____________________
Illicit Drug Use	☐	☐	If yes, how often?____________________

DIALATION PROTOCOL

HERE AT ANNA EYECARE WE STRIVE TO GIVE YOU THE BEST QUALITY CARE POSSIBLE. THE STANDARD OF CARE FOR OCCULAR HEALTH IS A DILATED EXAM. A DILATED EXAM IS IMPORTANT BECAUSE IT ALLOWS MORE OF THE INTERNAL STRUCTURES OF THE EYE TO BE VIEWED IN ORDER TO RULE OUT RETINAL PATHOLOGIES INCLUDING DETACHMENTS, TEARS, TUMORS, ETC. COMMON SIDE EFFECTS INCLUDE SENSITIVITY TO LIGHT AND REDUCED NEAR VISION. THESE SIDE EFFECTS USUALLY LAST 2-4 HOURS. PLEASE CHECK ONE OF THE FOLLOWING BOXES BELOW. *THERE IS AN ADDITIONAL CHARGE OF **$20.00** FOR THIS SERVICE.

( ) I WOULD LIKE TO HAVE A DILATED FUNDUS EXAM PERFORMED TODAY

( ) I UNDERSTAND THE IMPORTANCE OF THE DILATED FUNDUS EXAM, BUT I DO NOT WISH TO BE DILATED TODAY

Patient/Guardian Signature______________________________ Date____________

Anna Eyecare, PA
Dr. Christopher R Jackman, O.D.
1108 W. White St., Suite 200
Anna, TX 75409
972-924-8889 Office
972-924-8555 Fax

Privacy Practices Acknowledgement Form

I, ______________________________ (Patient's Name), have received a copy of the Summary of the HIPAA Privacy Rule and/or have been provided the opportunity to review it. I authorize the use and disclosure of my health information (including diagnosis and records) for the purpose of treatment, filing insurance claims, and healthcare operations.

Signature ______________________________ Date __________

If signing as a personal representative of the patient, please describe your relationship to the patient.

Relationship to Patient ________________ Print Name ____________________

Release of Information

I authorize the release of information including diagnosis, records, examination rendered to me, and claims information to the following (please clearly write the name of the person next to the box(es) you check):

[] Spouse ______________________________________
[] Child(ren) ____________________________________
[] Primary Care Physician ___________________________
[] Other ____

[] Information is not to be released to anyone.

*This **Release of Information** will remain in effect until terminated or amended by me in writing.*

Messages

Please clearly write the phone number or email address next to the box(es) you check.

Please call [] my home ____________________ [] my work______________________
[] my cell ____________________ [] email ______________________

If unable to reach me:

[] you may leave a detailed message
[] please leave a message asking me to return your call
[] you may leave a message with the person who answers my phone
[] other instructions ____

Signature______________________________ Date ______________