# PLEASE SIGN IN

**NAME** _____, _____ **DATE:** ____/____/20___

**( LAST)** **(FIRST)**

**(PATIENT/GUARDIAN, if under 18** _____, _____ **RELATION TO PATIENT** _____**)**

**ADDRESS** _____ **APT** _____ **CITY** _____ **ST** _____ **ZIP** _____

**PHONE # (_____)** _____ **-** _____ **DATE OF BIRTH** ____ /____ / ____ **OCCUPATION**_____

**EMAIL** _____ (Your email address will ONLY be used for correspondences from *our office*)

How did you hear about us? ☐ Friend/Relative ☐ Another Patient ☐ Another Physician ☐ Our Sign ☐ Internet

☐ Other: _____ Whom may we thank for referring you to us? _____

When was your last eye exam**?** _____ Last ***dilated*** eye exam**?** _____ Last medical exam? _____

Reason for today's exam_____

Is today's examination for Contact Lenses? ☐ Yes ☐ No ☐ Not Sure **Are you pregnant or nursing?** ☐ Yes ☐ No

Do you experience / have you ever had any of the following:

| | | | | |
|---|---|---|---|---|
| ___ severe eye pain | ___ itching | ___ redness | ___ dryness | ___ tearing/discharge |
| ___ swelling | ___ glare | ___ "flashes" of light | ___ "floaters" or spots | ___ overly light sensitive |
| ___eye injury | ___ eye surgery | ___ eye infection/disease | ___ eye strain (currently) | ___ medical eye treatment |

___other_____

Do you ("**ME**") or anyone in your family ("**F**") have any of the following?

| | | | | |
|---|---|---|---|---|
| ___ glaucoma | ___ cataracts | ___ lyme disease (you) | ___ high cholesterol | ___ diabetes |
| ___ overly light sensitive | ___ "lazy" eye | ___ "hay fever" | ___ hypertension | ___ arthritis |
| ___macular degeneration | ___ turned eye | ___ thyroid disorder | ___ cancer/malignancy | ___ HIV/AIDS/other VD |
| ___ detached retina | ___ blindness | ___ kidney disorder | ___ surgery (you) | ___ headaches/migraines |

___other_____

Please list **any** allergies you have ( ☐ none) _____

Please list **all** medications you are currently taking; including over-the-counter, oral contraceptives, aspirins, vitamins, supplements, home remedies ( ☐ none ) _____

Please list **all** eye drops you are currently taking ( ☐ none) _____

**PLEASE READ AND CHECK BOX**

It is our philosophy as the independent eye doctors at ***Ressler Optometry*** is to provide premiere ocular health care for all of our patients. We do our best to achieve a prescription that suits every patient's individual needs. We also provide a comprehensive medical eye examination. In doing so, ***we strongly recommend an annual dilated fundus examination*** ($25) which medically examines the internal components of the eye. This enables us to check for many diseases including *glaucoma, cataracts, ocular cancer, retina detachments, hypertension/hypertensive eye disease, diabetes/diabetic eye disease, and other ocular pathology*. Anyone with any **personal OR family history** of (among others) cataracts, diabetes, hypertension, heart disease, cancer, thyroid, glaucoma, macular degeneration, symptoms of flashes/floaters, HIV +/ AIDS/OTHER STD's, lyme disease, strong prescription, or a glaucoma, or "lazy" eye should **especially** have this performed **annually,** regardless of age.

I have read the above paragraph and …

☐ I would like to be dilated today ☐ I will return for the dilation

☐ I do not want to be dilated today ☐ I would like to discuss this further with the doctor

Signature**:**_____