Welcome Back to Optical Concepts!

Name ____ **Preferred Name**_______________ ☐**Male** ☐**Female**
Date of Birth ________/_______/___________ **Social Security #** ___________-_________-__________
Address: Street ____
City_____________________________ **State**________ **Zip**__________
Phone: Home _______________________ **Cell** _______________________ **Work** ______________________

Email____

Ethnicity	**Preferred Language**	**Race**	
☐Decline to specify	☐Decline to specify	☐Decline to specify	☐Hispanic
☐Hispanic/Latino	☐English	☐Alaska Native	☐Native Hawaiian or Other Pacific Islander
☐Not Hispanic/Latino	☐Spanish	☐Asian	
	☐Other ___________	☐Black/African-American	☐White

Occupation____________________________
Marital Status ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Employment Status ☐Employed Full-Time ☐Employed Part-Time ☐Retired ☐Full-Time Student

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PHARMACY:
Name ____
Phone Number ____________________________________
Town ____

PRIMARY CARE PHYSICIAN
Date of last physical exam: _____/_____/______
Dr . _______________________________________
Phone Number ____________________ Fax ________________

MEDICATION/ VITAMIN/ SUPPLEMENT LIST:

___________________________________ ___________________________________ ___________________________________

___________________________________ ___________________________________ ___________________________________

Emergency Contact Name __________________________________ Phone Number___________________________________

***Are you Currently experiencing any of the following*:**

Yes	No		Yes	No	
☐	☐	Blurry vision when using a computer			
☐	☐	Blurry vision when reading	☐	☐	Burning/pain
☐	☐	Blurred distance vision	☐	☐	Itching
☐	☐	Difficulty seeing at night	☐	☐	Excessive tearing/watery eyes
☐	☐	Problems with nighttime driving	☐	☐	Tired eyes
☐	☐	Glare	☐	☐	Contact lens discomfort
☐	☐	Flashing lights	☐	☐	Sandy or gritty feeling in the eyes
☐	☐	Floaters	☐	☐	Discharge
☐	☐	Double vision	☐	☐	Redness
☐	☐	Headaches	☐	☐	Light sensitivity

Have you had any ocular surgeries? Explain ________________________ When ___________________________________

Have you ever injured your eyes? How __________________________ When ___________________________________

Do you use any eye drops? No___Yes ___Name _______________ How Often ________________________________

MEDICAL HISTORY:

Do you drink alcohol? ☐No ☐Yes, how often ____________
Do you smoke? ☐No ☐Yes, how often ____________ If quit, how long ago______________________

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Allergic/Immunologic
- ☐ Drug allergy__________
- ☐ Environmental allergy
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ Other______________

Cardiovascular
- ☐ Heart disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Vascular disease
- ☐ High cholesterol
- ☐ Other______________

Constitutional
- ☐ Developmental disability
- ☐ Weight loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other______________

Endocrine
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Thyroid dysfunction
- ☐ Hormonal dysfunction
- ☐ Other______________

Gastrointestinal
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Digestive
- ☐ Acid reflux
- ☐ Other______________

Genitourinary
- ☐ STD
- ☐ Bladder
- ☐ Prostate
- ☐ Other______________

Ear, Nose, Mouth, Throat
- ☐ Inner ear
- ☐ Sinus
- ☐ Hearing loss
- ☐ Other______________

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Leukemia
- ☐ Other______________

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Other______________

Musculoskeletal
- ☐ Fibromyalgia
- ☐ Muscular dystrophy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Other______________

Neurological
- ☐ Cerebral palsy
- ☐ Multiple sclerosis
- ☐ Parkinson's
- ☐ Epilepsy
- ☐ Other______________

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Panic disorder
- ☐ Schizophrenia
- ☐ ADD/ADHD
- ☐ Other______________

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Other______________

List any hospitalizations, surgeries or additional details you would like to provide:

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FAMILY HISTORY *(Parents, Siblings or Children)*

Medical Condition			Relationship
High Blood Pressure	Y	N	________________
Diabetes	Y	N	________________
Heart Disease	Y	N	________________
Cancer	Y	N	________________
Stroke	Y	N	________________
High Cholesterol	Y	N	________________
Kidney Disease	Y	N	________________

Ocular Condition			Relationship
Glaucoma	Y	N	________________
Cataracts	Y	N	________________
Macular Degeneration	Y	N	________________
Blindness	Y	N	________________
Retinal Detachment	Y	N	________________
Other Conditions	Y	N	________________

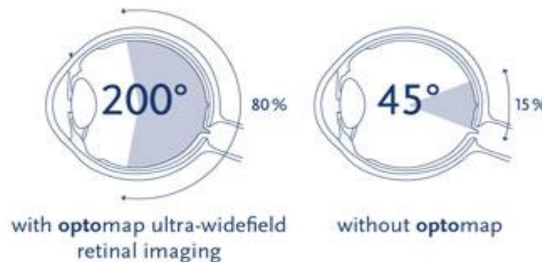
I certify that information pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Optical Concepts. I authorize release of medical information necessary to process this (these) claim(s). I have read all terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

Signature: ____ **Date:** ______________________________

We recommend including Optomap Imaging as part of Your Comprehensive Eye Exam.

Benefits of the Optomap:

- **Early detection of sight-threatening conditions such as glaucoma, macular degeneration and retinal holes or tears.**
- **Early detection of diseases like Cancer, Stroke and Cardiovascular disease.**
- **Immediately review results with us in the Exam Room.**
- **Can be done instead of dilating your eyes.**
- **Is as fast as taking a picture.**
- **DOES NOT REQUIRE DILATING DROPS.**



Your insurance/vision plan is designed to allow a basic eye exam and may not cover advanced screening tools such as the Optomap. We believe this state of the art technology is in our patient's best medical interest.
The Optomap screening is only $45.

- *_____ *Yes, I am interested in using the Optomap Technology*
- *_____ *I would like more information about Optomap*

*~Optical Concepts * Your Neighborhood Eye Care Professionals~*