*Family Eye Care*

**ID#** **Medical History Questionnaire**

Name:_____Date of Birth:_____

Date:_____

**Email Address:**_____**Cell Phone:** _____

**How would you like to be notified of appointments?___Home___Cell___Work___Email____Postal**
**Is texting your cell phone for appointment reminders okay? ___Yes ____No**

**Preferred Pharmacy:** _____

**Height: _____ Weight: _____**

Number of alcoholic drinks per day _____
Number of cigarettes per day _____

**Primary Care Physician:**_____ **Are you pregnant? Yes__No__**

**If diabetic, what was your last blood sugar and time_____ A1C(3 month average)_____**

**Reason for visit:**_____

_____

**Please check all the following conditions that you experience:**

| | | |
|---|---|---|
| ☐Headaches | ☐Glare/Light Sensitivity | ☐Tired Eyes |
| ☐Burning | ☐Dryness | ☐Eye Pain or Soreness |
| ☐Foreign Body Sensation | ☐Infection of Eye or Lid | ☐Itching |
| ☐Mucous / Discharge | ☐Drooping Eyelid | ☐Redness |
| ☐Sandy or Gritty Feeling | ☐Lazy Eye | ☐Crossed Eye |
| ☐Blurred Vision Distance | ☐Blurred Vision Near | ☐Distorted Vision |
| ☐Double Vision | ☐Floaters or Spots | ☐Fluctuating Vision |
| ☐Loss of Vision | ☐Excessive Tearing | ☐Loss of Side Vision |
| ☐Halos / Starbursts around lights | ☐Flashes of Light | ☐Excessive Eye Rubbing |

**Students:**

☐Trouble following a line of print ☐Trouble focusing on electronic device ☐Trouble focusing near to far

**If you marked any of the above or have a condition not listed, please explain below.**

_____

_____

**Please list any eyedrops/eye ointments, dosages, frequency and why you take them:**

_____

_____

**Do you have any drug allergies? Yes____No___ If yes, please list them:**

_____

**Signature** _____ **Date**_____

**Family Eye Care**
**100 N Main Street**
**LaBelle, FL 33935**

# Information Regarding Dilating Eye Drops and Refraction

**<PatFullName>** **<DateToday>**

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the optometrist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your optometrist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Parrish and/or Dr. Youmans or their assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

## Refraction NON COVERED SERVICES

Medicare and most other insurance companies do not pay for the refraction part of the eye exam. If a refraction (part of exam that determines your need for glasses) is necessary during the exam, the insurance company will disallow it, stating it is not a covered benefit. Therefore, the patient will be responsible for the refraction charge.

_____ _____
Patient Signature (or Authorized Person) Date

_____ _____
Witness Date