

WELCOME BACK TO SUMNER VISION

Returning Patient Medical History Update

Name _____ DOB _____ Age _____ Date _____

Demographic Update

Please record changes in your address or phone numbers, etc.

No Changes since last exam.

New Address _____

New Phone Number Work Cell Phone Home

New Email Address _____

New Major Medical Insurance Company
(this is usually different from your vision insurance)

How Is Your General Health?

Excellent Good Fair Poor

Please state any changes in your family, personal medical and eye history since your last exam. Same as last exam

Please list current medications Same as last exam

Lifestyle Questions

(Please check those that apply)

Please list recreational activities

I participate in sports

I am interested in changing my eye color

I use power tools

I work at a computer at least 2 hours per day

Contact Lens History

How often do you wear your lenses? _____

How often do you replace your lenses? _____

How often do you wear your lenses overnight? _____

What solutions do you use? _____

Is there anything you would like to see improved with your contact lenses? _____

Patient's Eye Health & Visual Symptoms

(N=Never S=Sometimes O=Often A=Always)

Do your eyes ever feel or do you experience:

Gritty or sandy sensations?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Pain or soreness?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Fluctuating vision?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Occasional tearing?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Swollen eye lids?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Blurred vision while reading?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Discomfort in windy conditions?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Discomfort in air conditioned areas?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Dryness?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Double vision?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Redness?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Mucous discharge?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Itching?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Burning?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Glare or light sensitivity?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A
Flashes or floaters?	<input type="checkbox"/> N	<input type="checkbox"/> S	<input type="checkbox"/> O	<input type="checkbox"/> A

Do you currently take any of the following medications?

Antihistamines Hormones Antidepressants

Diuretics Beta Blockers

Do you use artificial tears? Yes No

If yes, how long does the relief last? _____

Typically, how many artificial tear drops do you use per day?

2 3 4 or more

Do you use eye drops for red or itchy eyes? Yes No

Are you interested in Laser Vision Correction? Yes No

Would you like to hear about CRT, a safe non-surgical alternative to LASIK? Yes No

If you do not wear contacts lenses, would you be interested in learning about the new, more convenient contact lens products now available? Yes No

Informed Consent for Dilated Exam

It is recommended that your pupils be dilated every 2 years or more often if necessary to rule out eye disease that may cause loss of sight or worse. Your pupils will be dilated for 2 to 4 hours, and your vision will be temporarily blurry, especially for near activities. Your eyes will be sensitive to sunlight, possibly making driving home and other activities somewhat difficult. If necessary, your dilation can be scheduled for a more convenient time.

Please check one and initial:

I agree to be dilated today. _____

I do not agree to be dilated but will schedule for another time. _____

I refuse to have my eyes dilated because _____.