GOLDEN EYE CLINIC

Name: ____ Date of Birth: _______________ Today's Date: _______________

Current address:____City:______________________Zip____________________

Driver's License#:______________________________ Phone numbers:(Please list all reachable #s)____

SS#______________________________ Email address:____

My information may be released to:____________________________ Reason for today's visit: "____."

Are you planning to get new glasses today? Yes – No – Only if Rx changes | Are you planning to get new contacts today? Yes – No – Only if Rx changes

Family Doctor: ____ Last Eye Exam? __________________ By whom? ___________________________

Are you being seen by a hospice nurse? ________ If applicable; Parent's names:____

Please list all medications you are currently taking: ____

DRUG ALLERGIES: ____

Of the following options, which would you consider to be your race?
American Indian or Alaska native Asian Black or African American
Native Hawaiian or other pacific islander White Other race

Of the following option, which would you consider to be you ethnicity?
Unknown Not Hispanic or Latino Hispanic or Latino

Are you a smoker? 1. Current every day smoker 2.Current some day smoker 3.Smoker 4.Former smoker 5.Never smoker

Dr. Golden and Dr. Mackey recommend that everyone of any age have an Optomap test ($30) done for the purpose of getting an excellent image of the retina. They also recommend that every patient over the age of forty get an Optomap and Optovue wellness retina scan. This technology represents the highest level of testing for retinal eye diseases. The total wellness exam of both the Optos and Optovue is $45. Having this done will take place of being dilated. <u>These tests are not covered by your insurance.</u>

Please check one: ______Dilation ______Optomap ($30 Extra) _____Optomap & Optovue ($45 Extra)

REVIEW OF SYSTEMS

CONSTITUTIONAL
- ☐ Fever
- ☐ Weight loss/gain

CARDIOVASCULAR
- ☐ Hypertension
- ☐ Stroke
- ☐ Heart disease/problems
- ☐ High cholesterol

EAR, NOSE, MOUTH THROAT
- ☐ Sinus infection
- ☐ Ear infection
- ☐ Hearing loss

RESPIRATORY
- ☐ Asthma/shortness of breath
- ☐ Bronchitis/emphysema

GASTROINTESTINAL
- ☐ Gastric reflux
- ☐ Liver problems

GENTOURINARY
- ☐ Genital/Kidney/Bladder

MUSCULOSKELETAL
- ☐ Rheumatoid arthritis
- ☐ Joint/muscle/back pain

INTEGUMENT
- ☐ Rosacea
- ☐ Metal allergies
- ☐ Skin cancer

NEUROLOGICAL
- ☐ Headaches
- ☐ Seizures
- ☐ Alzheimer's/Parkinson's

PSYCHIATRIC
- ☐ Depressed/mood swings
- ☐ Nervousness

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid/other glands

LYMPHATIC/HEMATOLOGIC
- ☐ Anemia
- ☐ Blood disorders

ALLERGIC/IMMUNOLOGIC
- ☐ Allergies/hay fever
- ☐ HIV
- ☐ Lupus

EYE SURGERIES

Surgery:_____________
Date: ______________
Dr: ________________
Surgery:_____________
Date:______________
Dr:________________
Surgery:_____________
Date:______________
Dr:________________

PAST/PRESENT EYE HISTORY:

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Retinal disease (holes, etc.)
- ☐ Dry eye
- ☐ Eye injury (black eye, etc.)
- ☐ Blindness
- ☐ Eye turn/lazy eye
- ☐ Diabetic retinopathy
- ☐ Other_______________

FAMILY HISTORY:

- ☐ Blindness
- ☐ Strabismus (eye turn)
- ☐ Amblyopia (lazy eye)
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular degeneration
- ☐ Retinal disease
- ☐ Cancer
- ☐ Hypertension
- ☐ Heart disease
- ☐ Other ___________

EYES/OCULAR SYMPTOMS:

- ☐ Decreased distance vision
- ☐ Decreased near vision
- ☐ Loss of side vision
- ☐ Fluctuating vision
- ☐ Glare/light sensitivity
- ☐ Double vision
- ☐ Chronic eye or lid infection
- ☐ Flashing lights/floaters
- ☐ Headaches
- ☐ Mucous discharge
- ☐ Dryness
- ☐ Itching
- ☐ Sandy or gritty feeling
- ☐ Burning

RELEASE & AUTHORIZATION & PRIVACY PRACTICE NOTICE: I have reviewed this Notice of Practice Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. I hereby authorize release of an information concerning my (or my child's) examination and treatment provided for the purpose of evaluation and administering claims for insurance benefits. **I also authorize payment directly to the doctor for any insurance benefits otherwise payable to me. I realize this may not represent full payment and understand I will be responsible for the balance due after any insurance is collected.**

______________________________________ ______________________________ ____________________

Signature of Patient or Personal Representative Relationship to Patient Today's Date