TODAY'S VISION

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____ Age: _____

Date of Birth: _____/_____/_____ Gender: ( ) Male ( ) Female Race: _____ Ethnicity: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell: (_____)_____ Home: (_____)_____ Work: (_____)_____

Email: _____

Guarantor (if patient is a dependent):

Name: _____ Date of Birth: ___/___/____ Relation to Patient: _____

Reason for visit:_____

_____

Please check all that apply

Eye Concerns:

___ redness
___ tearing
___ burning
___ discharge

Visual Concerns:

___blurred vision
___ eye pain
___ eye strain
___ double vision
___ total loss of vision
___ severe sensitivity to light
___ headache
___ poor night vision
___ bothersome night glare
___ struggle for grades in school

Eye Conditions:

self	blood relative	
___	___	glaucoma
___	___	blindness
___	___	cataract
___	___	lazy eye
___	___	dry eye
___	___	macular degeneration

last eye exam _____

last dilation _____

last physical exam _____

Medical History:

self	blood relative		self	blood relative		
___	___	diabetes	___	___	heart disease	___ pregnant/nursing
___	___	cancer	___	___	hypertension	___ alcohol use
___	___	arthritis	___	___	respiratory problems	___ smoker
___	___	headache	___	___	shingles	___ eye surgery
___	___	HIV	___	___	thyroid disease	___ medication allergies
___	___	hepatitis	___	___	high cholesterol	
___	___	lupus	___	___	kidney disorder	_____

Current Medications: _____

_____

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Contact Lens Wear:

Brand: _____ Replacement Schedule: ___daily ___ 2 weeks ___ monthly ___ other

Do you sleep in your contacts? ___ yes ___ no Age of current lens? _____

Cleaning solution used: _____ Problems with lenses? _____

Glasses Wear:

Do you currently wear glasses? ___ yes ___ no Have you ever worn prescription glasses ___ yes ___ no

Age of glasses? _____ Age you began wearing glasses? _____

Troubles or concerns with your current glasses? _____

Desires for next pair of glasses: _____

Pupil Dilation:
Dilation is standard procedure for a comprehensive eye examination. Dilation assists in the detection of glaucoma, cataracts, diabetic and hypertensive retinal changes, retinal holes or tears, and some types of tumors and headaches. Dilating drops enlarge the size of the pupil and allows the doctor a more thorough examination of the retina(back of the eye). The side effects are light sensitivity for 4 to 6 hours and trouble focusing up close for 2 to 3 hours. It is possible, though unlikely, that a dilation could cause a sudden rise in eye pressure. If the doctor determines you are at risk your pupils will not be dilated. Most people are able to drive home, however, if you are uncomfortable driving, or if you feel unsafe driving, please arrange for someone else to drive you.

I AGREE to dilation ___ Today ___ Not Today signature: _____ Date: _____

iWellness:
The iWellness is a quick non-invasive scan that allows Dr. Swift to see beneath the surface of your retina. This scan can help detect the beginning stages of various eye diseases. For more information please read attached sheet. The iWellness scan is typically not covered by vision or medical insurance. The $39 charge will be added to the cost of your visit today.

I AGREE to iWellness _____YES _____NO