Vision Clinic, Dr. Savin & Associates

Date____________________ Name you wish to be called:______________________________
Name______________________________ Sex: M F Date of Birth____________________
Address______________________________ City____________ State______ Zip__________
Soc.Sec.#______________ Responsible Party/Parents______________ Spouse__________
Phone(H)____________________ (W)____________________ (Cell)____________________
Email____________________ Occupation______________ Employer______________
Reason for visit____
Ages of children living at home______________________ Referred by______________

Ocular History

Date of last eye examination______________
By whom______________
Do you wear glasses? Yes No
For: Distance_____ Near_____ Other_____
Date prescribed:______________
Contact Lenses: Yes No

Do you experience any of the following?

Blurred vision	Yes No
Double vision	Yes No
Eye Strain/Fatigue	Yes No
Headaches	Yes No
Eye Pain	Yes No
Burn, itch, tear	Yes No
Lazy/wandering eye (left or right)	Yes No
Flashes of light	Yes No
Light sensitivity	Yes No
Loss of field of vision/restricted field	Yes No
Squinting	Yes No
Frequent blinking	Yes No
Redness	Yes No
Floaters	Yes No
Covers or closes an eye (left or right)	Yes No
Rubs eye	Yes No
Dryness	Yes No
Watery Eyes	Yes No
Uncomfortable or inefficient reading	Yes No

Medical History

Last Medical exam______________
By whom______________
General health: Excellent Good Fair Poor

Do you presently have problems in the following areas?

Allergies, immune system	Yes No
Sinus, ears, nose	Yes No
Respiratory (lungs, breathing, TB)	Yes No
Cardiovascular (heart, blood pressure)	Yes No
Stomach, colon	Yes No
Bones, joint, arthritis, muscles	Yes No
Hepatitis	Yes No
Endocrine (diabetes, thyroid)	Yes No
Skin	Yes No

Medical History (cont.)

Rosacea	Yes No
Blood	Yes No
Behavioral, depression	Yes No
Are you pregnant?	Yes No
History of stroke or head injury	Yes No
Dizziness/Vertigo	Yes No
Difficulty in attention and concentration	Yes No
STD	Yes No
High Cholesterol	Yes No
HIV/AIDS	Yes No
Multiple Sclerosis	Yes No
Psychiatric	Yes No
Anxiety	Yes No

Do you have a history of any of the following?

Brain injury	Yes No
Ear infections	Yes No
Eye surgery	Yes No
Eye injury	Yes No
Eye disease	Yes No
Cataracts	Yes No
Glaucoma	Yes No
Vision loss	Yes No

Please list all medications you are currently taking and Why______________________________
____

Please list all allergies (incl. drugs)______________________________
____

Family History

Cataracts	Yes No
Glaucoma	Yes No
Macular Degeneration	Yes No
Lazy/Wandering eye	Yes No
Retinal Problems	Yes No
Blindness	Yes No
Diabetes	Yes No
High Blood Pressure	Yes No
Cardiovascular disease	Yes No
Neurological disease	Yes No
Arthritis	Yes No

Medical Information Release Form

(HIPAA Release Form)

Name: ______________________________ **Date of Birth:** _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse__________________________________

[ ] Child(ren)________________________________

[ ] Other___________________________________

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_______________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ____________________________________

The best time to reach me is (*day*)________________ between (*time*)________

Signed: ________________________________ Date: ____/____/_____

Witness:________________________________ Date: ____/____/_____

1421 Washington Ave. Racine, WI 53403 ● 637-7494

Welcome To The 21st Century Eye Wellness Exam

Dear Patient:

A highly sophisticated Retinal Analyzer/Imager now allows us to provide you with a more thorough medical examination of your eyes. The Retinal Analyzer System takes scans of the retina (the inside of your eye). This revolutionary Eye Wellness Exam assists your doctor in the early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, macular holes, retinal detachments, and other vision threatening conditions. The retinal scans will become part of your records for comparison with retinal scans from future exams. This allows your doctor to observe even the smallest amount of change from the previous Eye Wellness Exam.

Retinal Scanning/Imaging is especially important for people with:
(check all that apply)

- o Headaches
- o Spots or flashes in vision
- o A family history of glaucoma, macular degeneration, diabetes, cancer or high blood pressure
- o High cholesterol
- o Reached the age of 40
- o Never been examined in our office
- o History of heavy smoking
- o High refractive error/prescription

The Doctors of Vision Clinic Dr. Savin & Associates highly recommend yearly Retinal Imaging if you checked any of the boxes above.

There is an additional fee for this procedure of $34. This procedure is a Wellness Screening and is **not** covered by any insurance. Please check the appropriate line below and sign at the bottom.

____ I choose **To have** the Eye Wellness Exam performed

____ I choose **Not to have** the Eye Wellness Exam performed

____
Printed Name

______________________________ ______________________________
Signature Date