Medical History Questionnaire

Name: _____ Today's Date: _____ / _____ / _____

Address: _____ Phone: _____

City: _____ Zip: _____ Work Phone: _____

Guardian (If Applicable): _____ Occupation: _____

Birth Date: _____ / _____ / _____ Social Security #: _____ / _____ / _____ Last Eye Exam: _____ / _____ / _____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Last Medical Exam: _____ / _____ / _____

Medical History

Do you have any allergies to medications? ❒ no ❒ yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? ❒ no ❒ yes

Do you wear glasses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ yes ❒ no

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❒	❒	❒	
Cataract	❒	❒	❒	
Crossed Eyes	❒	❒	❒	
Glaucoma	❒	❒	❒	
Macular Degeneration	❒	❒	❒	
Retinal Detachment/Disease	❒	❒	❒	
Arthritis	❒	❒	❒	
Cancer	❒	❒	❒	
Diabetes	❒	❒	❒	
Heart Disease	❒	❒	❒	
High Blood Pressure	❒	❒	❒	
Kidney Disease	❒	❒	❒	
Lupus	❒	❒	❒	
Thyroid Disease	❒	❒	❒	
Other _____	❒	❒	❒	

✳ Please turn this form over and complete side two ✳

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❒ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❒ no ❒ yes If yes, do you have visual difficulty when driving? ❒ no ❒ yes If yes, please describe:

_____

Do you use tobacco products? ❒ no ❒ yes If yes, type/amount/how long: _____

Do you drink alcohol? ❒ no ❒ yes If yes, type/amount/how long: _____

Do you use illegal drugs? ❒ no ❒ yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❒	❒	❒
INTEGUMENTARY (Skin)	❒	❒	❒
NEUROLOGICAL			
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
EYES			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision/Halos	❒	❒	❒
Loss of Side Vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing/Watering	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Chronic Infection of Eye or Lid	❒	❒	❒
Sties or Chalazion	❒	❒	❒
Flashes/Floaters in Vision	❒	❒	❒
Tired Eyes	❒	❒	❒
ENDOCRINE			
Thyroid/Other Glands	❒	❒	❒

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Runny Nose	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat/Mouth	❒	❒	❒
RESPIRATORY			
Asthma	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
VASCULAR / CARDIOVASCULAR			
Diabetes	❒	❒	❒
Heart Pain	❒	❒	❒
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
GASTROINTESTINAL			
Diarrhea	❒	❒	❒
Constipation	❒	❒	❒
GENITOURINARY			
Genitals/Kidney/Bladder	❒	❒	❒
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
LYMPHATIC / HEMATOLOGIC			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
ALLERGIC / IMMUNOLOGIC	❒	❒	❒
PSYCHIATRIC	❒	❒	❒

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

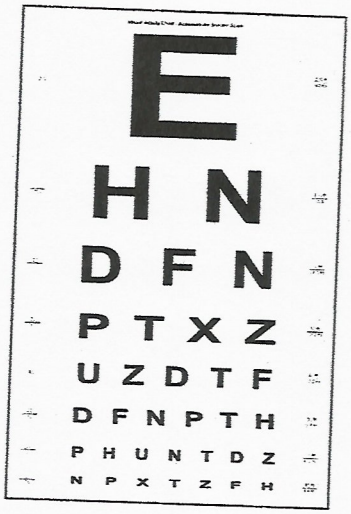
_____

_____

_____

_____ _____

Doctor's Signature Date



F & M FAMILY EYECARE
7583 HIGHWAY 85
RIVERDALE, GA 30274
TEL: 770-996-3495 FAX: 770-996-3429

Dilated Fundus Examination

Pupil dilation is absolutely recommended for all of our patients. Pupil dilation allows a doctor to examine the retina for holes, tears, detachment, tumors (benign or malignant), leaking blood vessels and other retinal anomalies. Dilation is especially helpful in the diagnosis of glaucoma, cataracts, unexplained vision decrease, and even brain tumors. Having the pupils dilated for your exam can literally save the vision by detecting problems earlier in their development. People with a personal or family history of headaches, diabetes, hypertension, or who have a personal history of head or eye injuries, or who have never had a comprehensive dilated eye exam, or who have a high prescription are particularly at risk and must have a comprehensive dilated eye exam regularly.

The most common side effects of the drops used are increased light sensitivity and reduction in near focusing ability. Distance vision is not significantly affected and most people have no trouble driving afterwards. If you do not have sunglasses with you, we will provide post-dilation glasses, and would be happy to help you obtain proper sun protection for future use. The process is painless, and lasts approximately 4 to 5 hours.

I understand the importance of pupil dilation in a complete eye examination.

I do_____ I do not_____ give my permission to have my/my dependent's eyes dilated.

PATIENT NAME (PRINT): _____

PATIENT SIGNATURE: _____ DATE: _____

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RETINAL IMAGING

We are pleased to announce the incorporation of retinal imaging into our practice. This is a sophisticated high tech instrument that allows us to provide a more thorough medical evaluation of your eye.

Our retinal imaging device captures a digital image of the central and peripheral retina showing the blood vessels, macula and optic nerve. This picture is permanently stored in a computerized database for analysis and future reference to monitor changes in your eye.

Unfortunately, routine eye exams for glasses do not detect many diseases in their early stages. This wide angle retinal photography scan assist in the early detection of many diseases including brain tumors, glaucoma, diabetic retinopathy, hypertensive retinopathy, retinal detachment, Optic nerve disease and retinal disturbances due to systemic medications.

This imaging is especially important for patients who have or have had:

1. History or family history of Glaucoma
2. History of headache /Migraines
3. History or family history of Diabetes
4. History or family history of High Blood Pressure
5. Spots in their vision and/or flashes of light
6. High degree of near-sightedness/ high eye glasses prescription.

This procedure takes less than 5 minutes of your time and there is an additional charge for it as this is not covered by vision plans. This charge is in addition to any insurance co-payment or deductible you may have.

Dr. Osayi recommends that retinal imaging be done yearly as part of your routine eye health exam.

Please check the appropriate line below and sign the bottom.

_____ I do want the retinal imaging for $29.00

_____ I do not want this medical test.

Patient Signature _____ Date _____