

HARTLAND EYE CARE - Welcome to our office

The information in this confidential personal history form is critical to the evaluation of your vision.

Name: _____ Date: _____

Very Important! Who may we thank for referring you to our office? Name of friend or relative _____

Another Dr. Insurance Listing Saw Sign/Building Yellow Pages Web Page Other _____

Approximate date of your last eye examination _____

What correction do you wear? (*Check all that apply*)

Prescription Sunglasses Prescription Glasses Contact lenses Computer Glasses Reading Glasses

Non prescription sunglasses

This is your opportunity to tell us about all areas in which your vision is not serving you well.

What is your main reason for coming here today?

Are there times when your vision (or present lens) isn't quite right?

Are there any activities you would enjoy doing, but must restrict because of your vision? _____

Are you interested in vision improvement? Refractive Surgery Non-Surgical Vision Correction

OCCUPATION: What kind of work do you do? _____

What activities do you do at work: (*Circle all that apply*) driving typing data entry computers program inspecting accounting writing/editing using spread-sheets loading deliveries sales monitor instruments.

Other activities: _____

Do you use a computer? . . . Yes No # hours daily _____ Distance from eyes to screen _____ inches

Do you experience any of the following discomforts at work or at home?

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Headaches? | <input type="checkbox"/> Letters blur as you read? | <input type="checkbox"/> Neck, shoulder or back pain? |
| <input type="checkbox"/> Eyestrain? | <input type="checkbox"/> Eyes red or watery? | <input type="checkbox"/> Pulling sensation near eyes? |
| <input type="checkbox"/> Get sleepy? | <input type="checkbox"/> Lose your place often? | <input type="checkbox"/> Driving vision worse in evening? |

Screening Tests for Eye Health

Modern technology allows us to offer testing to patients who may have very early glaucoma that would otherwise be undetected by a routine eye exam. As many as 50% of patients who develop glaucoma have normal eye pressure and they would only be diagnosed after years of permanent damage to their optic nerve. There are no symptoms from glaucoma until the damage is severe.

Dr. Doud strongly recommends this testing for your benefit.

Please circle accept or decline and sign the form as you prefer below:

Glaucoma screening (GDX and FDT)

I accept / decline - Patient Signature: _____

I understand that the fee of \$31 is not covered by my insurance company. I understand that without this testing Dr. Doud cannot completely rule out glaucoma. He will check my pressure and take a careful look at my optic nerve but many times this isn't enough to rule out glaucoma.

Retinal Photo - For all patients over 30 I recommend a digital photo of the optic nerve and retina so that we have permanent documentation. This normally is only done once in your lifetime. The fee for this is only \$10.

I accept / decline - Patient Signature: _____

I understand the fee of \$10 is not covered by my insurance company.