NEW PATIENT ANNUAL EXAM

Today's Date _____
Name_____
Date of Birth ____ / ____ / _____ Sex M ☐ F ☐
Street_____
City_____ State _____ Zip_____
Last 4 of Social Security # _____
Occupation (or grade) _____
Preferred Phone _____
Email _____

Emergency Contact _____
Relationship _____
Phone number _____

Do you currently wear contact lenses?
☐ Yes ☐ No
Would you like to renew your contact lens Rx or try contacts?
☐ Yes ☐ No

Your Attention Please:

Dr. Garnsey strongly recommends using the Optomap camera to evaluate **ALL** patients' retinas (back of the eye) at **EVERY** annual eye exam. No dilation drops are needed for this scan and it provides a superior way of monitoring eye health over time.

☐ **Optomap** - ($29) Generally not covered by most insurances

☐ I decline the Optomap retinal evaluation against the doctor's recommendation. I am choosing to either **DECLINE** my retinal evaluation at my exam or **WILL VERBALLY** request a **DILATED** eye exam from the doctor.

Eye Conditions

Have you ever been diagnosed with the following?
(Please check the conditions that apply to you)

☐ Cataract
☐ Age-related Macular Degeneration
☐ Glaucoma
☐ Diabetic Retinopathy
☐ Dry Eye
☐ Iritis or Uveitis
☐ Retina defects or degenerations
☐ Please list any additional conditions/comments

_____

Family Medical History
Please check all that apply

☐ Thyroid
☐ Hypertension
☐ Diabetes
☐ Glaucoma Suspect
☐ Macular Degeneration

Social History

Do you drink alcohol more than occasionally?
Yes ____ No ____ If yes, how much? _____

Please Complete Page 2

Personal Medical History - Do you currently, or have you ever had any problems in the following areas:

ENT
- ☐ Hearing Loss
- ☐ Dry Mouth
- ☐ Other _____

Neurological
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke/CVA
- ☐ MS
- ☐ Migraine
- ☐ Epilepsy
- ☐ Autism Spectrum
- ☐ Other _____

Constitutional
- ☐ Extreme fatigue
- ☐ Other _____

Psychiatric
- ☐ Depression/Anxiety
- ☐ Attention Deficit
- ☐ Other _____

Cardiovascular
- ☐ Hypertension
- ☐ Stroke/CVA
- ☐ Heart Disease
- ☐ Other _____

Respiratory
- ☐ Cigarette Smoker
- ☐ Other _____

Genitourinary
- ☐ Pregnant/Nursing
- ☐ Other _____

Musculoskeletal
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Other _____

Integumentary
- ☐ Shingles
- ☐ Other _____

Endocrine
- ☐ Thyroid Dysf
- ☐ Type 2 Diabetes
- ☐ Type 1 Diabetes
- ☐ Other _____

Hematologic/Lymphatic
- ☐ High Cholesterol
- ☐ Other _____

Allergic/Immune
- ☐ Drug Allergies
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's Syndrome
- ☐ Other _____

Medications

Please list any Medications you take. If you are unsure of the name of the medication, please list what it is taken for (i.e. Blood Pressure or diabetes meds)

_____
_____
_____
_____
_____
_____

Allergies

Please list any known allergies

_____
_____
_____
_____
_____
_____

Agreement: The below signature signifies that I have completed and/or reviewed the information on this history form and agree it is accurate and up-to-date. I also agree to and understand the **Payment Policy, Notice of Privacy Practices Acknowledgement, Contact Lens fit agreement and Eyeglass Warranty** information which has been provided to me.

_____ _____

Patient Signature or Parent Guardian Signature Date

_____ _____