EDGE OPTICS PATIENT HISTORY QUESTIONAIRE

INFORMATION ABOUT YOU:

NAME: _____ TODAY'S DATE: _____ MALE/FEMALE

DATE OF BIRTH: _____ SS# _____ OCCUPATION: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ E-MAIL: _____

LAST EYE EXAM: _____ LAST MEDICAL EXAM: _____

VISION INSURANCE PLAN NAME: _____ PRIMARY MEMBER'S NAME _____

INSURANCE ID NUMBER: _____ (IF YOU HAVE THIS INFORMATION AVAILABLE)

ARE YOU HERE FOR GLASSES? Y/N ARE YOU HERE FOR CONTACTS? Y/N BRAND OF CONTACTS:_____

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? YES/NO IF SO, LIST:_____

MEDICATIONS CURRENTLY TAKING: _____

ARE YOU CURRENTLY PREGNANT? YES/NO

HAVE YOU HAD ANY EYE SURGERIES OR TRAUMA TO THE EYES? _____

DO YOU SEE FLASHES OF LIGHT, BLINDSPOTS IN VISION, OR BLACKOUTS? _____

YOUR MEDICAL HISTORY:

DO YOU SUFFER FROM:		HAVE YOUR EYES SUFFERED FROM:		HAS YOUR FAMILY SUFFERED FROM:	
HIGH BLOOD PRESSURE	YES ☐ NO ☐	STRABISMUS	YES ☐ NO ☐	BLINDNESS	YES ☐ NO ☐
DIABETES	YES ☐ NO ☐	LAZY EYE	YES ☐ NO ☐	GLAUCOMA	YES ☐ NO ☐
LUNG DISEASE	YES ☐ NO ☐	KERATOCONUS	YES ☐ NO ☐	DIABETES	YES ☐ NO ☐
SEIZURES	YES ☐ NO ☐	GLAUCOMA	YES ☐ NO ☐	CATARACTS	YES ☐ NO ☐
CANCER	YES ☐ NO ☐	DIABETIC RETINOPATHY	YES ☐ NO ☐	MACULAR DEGENERATION	YES ☐ NO ☐
LUPUS	YES ☐ NO ☐	MACULAR DEGENERATION	YES ☐ NO ☐	KERATOCONUS	YES ☐ NO ☐
RHEUMATOID ARTHRITIS	YES ☐ NO ☐	DRY EYES	YES ☐ NO ☐		
SARCOIDOSIS	YES ☐ NO ☐	IRITIS	YES ☐ NO ☐		
MULTIPLE SCLEROSIS	YES ☐ NO ☐	RETINAL DETATCHMENT	YES ☐ NO ☐		
HIGH CHOLESTEROL	YES ☐ NO ☐	CATARACTS	YES ☐ NO ☐		

WHAT SPORTS/HOBBIES ARE YOU INVOLVED IN? _____

WHAT PROTECTIVE EYEWEAR DO YOU USE FOR YOUR INTERESTS? _____

How Did You Hear About Edge Optics?!

□ Google search □ Facebook/social media □ Other _____
□ Friend (who, so we may thank them with a little gift?) _____

PLEASE REVIEW AND SIGN YOUR ACKNOWLEDGEMENT OF THE FOLLOWING EDGE OPTICS POLICIES AND PROCEDURES:

- POLYCARBONATE AND TREXA MATERIALS ARE REQUIRED TO PROVIDE IMPACT RESISTANCE PROTECTIONS FOR ALL CHILDREN'S GLASSES AND ANYONE INVOLVED IN SPORT OR WORK ACTIVITIES WHERE DANGER OF IMPACT TO THE EYES OR FACE IS PREVILANT.

  PLEASE SIGN ACKNOWLEDGEMENT:_____

- DUE TO THE DAMAGE TO THE EYES FROM INTENSE EXPOSURE TO UV LIGHT, WHICH INCREASES AT HIGHER ALTITUDES AND WITH REFLECTIVE SURFACES SUCH AS WATER AND SNOW, AND FOR CHILDREN'S EYES INCREASED SENSITIVITY AND LIMITED DEFENSES, SUN PROTECTION FOR THE EYES IN HIGHLY RECCOMENDED WITH 100% UV BLOCKING LENSES.

  PLEASE SIGN ACKNOWLEDGEMENT: _____

- I HAVE BEEN PROVIDED A COPY OF HIPAA PRIVACY PRACTICES (ATTACHED) AND UNDERSTAND MY RIGHTS.

  PLEASE SIGN ACKNOWLEDGEMENT:_____

FIELD OF VISION TESTING

Edge Optics recommends field of vision testing on all patients over the age of 12 on a yearly basis as an important part of your eye examination. Missing pieces to your field of vision may not be detectable under normal eye exam procedures. The field of vision testing can assist in the early detection of glaucoma, optic nerve disease, retinal disorders, and neurological issues like brain tumors.

The fee for this important test is $15, most vision insurances do not cover this cost. Please initial one of the following:

___ Yes, I give consent for completion of testing.

___ No, I decline to have the field of vision testing performed.