Joann M. Class, O.D. Ltd   Date:____________

Mr./Mrs./Ms.____Date of Birth________________Age_________________

Address____City________________State________Zip________________

Phone#__________________Occupation_______________________Physician_______________________________

Last eye exam_____________Where______________________Have you been seen at this office before?___Yes____No

Vision Insurance Provider________________________Medical Insurance Provider______________________________

Email address____

Do you have any allergies to medications: YES   NO If yes, please list______________________________________

List any medications you take:____

List major injuries, surgeries, or hospitalizations:____

OCULAR REVIEW OF SYSTEMS:

Do you currently have or have you ever had any of the following?

Blurred Vision	Y	N	Eye Infections	Y	N
Dry Eyes	Y	N	Cataracts	Y	N
Itchy Eyes	Y	N	Glaucoma	Y	N
Eye Discharge	Y	N	Macular Degeneration	Y	N
Tearing	Y	N	Retinal Detachment	Y	N
Floating Spots	Y	N	Lazy Eye	Y	N
Flashing Lights	Y	N	Eye Surgery	Y	N

Please give details for all "yes"________________________

Contact Lens Questions:

Are you interested in Contact Lenses?	Y	N
Have you ever worn Contact Lenses?	Y	N
Do you now wear contacts?	Y	N

What type____

How long have you had this pair?_____________________

Which disinfecting solution do you use?________________

Do you sleep in your contacts?	Y	N
Do your eyes feel irritated with contacts?	Y	N
Are you interested in color contact lenses?	Y	N

Family History: Please note any family member (parents, grandparents, sibling, children) with any condition

Blindness	Y	N	Who:____________________	Macular Degeneration	Y	N	Who:____________________
Glaucoma	Y	N	Who:____________________	Retinal Detachment	Y	N	Who:____________________
Heart Disease	Y	N	Who:____________________	High Blood Pressure	Y	N	Who:____________________
Diabetes	Y	N	Who:____________________	Cancer	Y	N	Who:____________________

Social History: This information is kept strictly confidential. If you prefer, you may discuss this portion directly with the Doctor.

Do you drive?	Y	N
Do you have difficulty driving?	Y	N
Do you drink alcohol?	Y	N
Are you pregnant or nursing?	Y	N

Do you use tobacco?	Y	N
Do you use street drugs?	Y	N

Have you been infected with:

_______HIV________Hepatitis_____Tuberculosis

Review of Systems: do you currently have or have you ever had any problems in the following areas? Please circle all that apply.

CONSTITUTIONAL
Fever, Weight loss, other

RESPIRATORY/NOSE/THROAT/EAR
Asthma, Emphysema, COPD, other

GASTROINTESTINAL
Crohns, Ulcer, IBS, other

INTEGUMENTARY (skin)
Herpes zoster (shingles), Rosacea, other

CARDIOVASCULAR
High Blood Pressure, Heart Disease, High Cholesterol, Stroke, other

HEMOTOLOGIC/LYMPHATIC
Leukemia, Anemia, Bleeding, other

NEUROLOGICAL
Headache, Migraines, Seizures, MS, other

BONES/JOINTS/MUSCLES
Rheumatoid Arthritis, Fibromyalgia, other

ALLERGIC/IMMUNOLOGIC
Allergies, Autoimmune Disease, other

ENDOCRINE
Diabetes, Thyroid, other

GENITOURINARY
Kidney, Bladder, other

PSYCHIATRIC
Anxiety, Depression, other

Doctor's signature____Date________________________

Joann M. Class, O.D. Ltd

DILATED FUNDUS EXAM

A dilated fundus exam is a more extensive examination of the retina. It involves putting drops in the eyes to enlarge the pupils. The doctor will need to dilate all high-risk patients. You are considered high risk if:

1. You are very nearsighted
2. You have had injury or trauma to the eye or head
3. You have recent onset of flashes, floaters, or severe headaches
4. You have diabetes or high blood pressure
5. The doctor is unable to view the retina due to cataracts or small pupil size
6. You have a family history of retinal detachment or degeneration

Even if you are not at high risk, you should periodically have a dilated exam to rule out retinal detachment, tumors, or any abnormalities. Many of these occur without symptoms and are not seen without dilation. The dilation drops may cause some blurred vision (mainly at near) and light sensitivity, which lasts about 4-6 hours. We will provide a complimentary pair of disposable sunshields.

YES, I would like my eyes dilated. Signed____________________________________

NO, I have chosen not to have this procedure, and I will not hold Joann M. Class, O.D. Ltd., or any of its employees or contractors responsible for any pathology undetected due to lack of diagnostic information that could have been obtained by dilation.

Signed____________________________________

_____ I want to speak to the doctor before making my decision.

CONTACT LENS PATIENTS ONLY

CONTACT LENS FOLLOW-UP DISCLAIMER

I have been made aware by the Doctor and the vision center staff, that a contact lens follow-up, which is included in the initial exam fee, is an integral part of an accurate contact lens examination. Additionally, I understand that a contact lens follow-up will require me to have my lenses in my eyes at the time of the follow-up appointment. By signing below, I acknowledge these facts. The consequences for failure to return for the follow-up appointment after 2 MONTHS OF RECEIPT OF TRIAL LENSES include, but are not limited to:

- I will be charged a fitting fee for the doctor services starting at $25 and up, depending on lens type. After 6 months, a full exam will be required.
- My finalized contact lens prescription will be back dated to the initial visit
- Inability to purchase contact lenses due to the fact that the prescription has not been finalized thru a follow-up appointment with the Doctor.

Patient Signature______________________________________Date______________________