Patient Information

1. *Please enter your information*

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____

Preferred Name: _____

Gender:
☐ Female
☐ Male

Marital Status:
☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widow ☐ Domestic Partners

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Preferred Phone Number:
☐ Mobile ☐ Home ☐ Work

Email: _____

Primary Care Physician: _____

Primary Care Physician Phone Number: _____

2. *Check off any of the following you experience when wearing your current visual correction (i.e. glasses or contacts)*

☐ Blurry Vision ☐ Floaters ☐ Flashes of Light
☐ Eye Strain ☐ Headaches ☐ Double Vision
☐ Itchy Eyes ☐ Dry Eye ☐ None of the above

Please specify any other issues you may be experiencing: _____

3. *Please indicate if you or a family member have any of the following Ocular Conditions*
   - *For family members, please explain relationship to you below*

Ocular Condition	You	Family	None
Amblyopia/Lazy Eye			
Blindness			
Cataracts			
Glaucoma			
Macular Degeneration			
Retinal Detachment			
Keratoconus			
Eye Injury (specify below)			
Eye Surgery (specify below)			

Please explain: _____

Continue on back

4. *Please indicate if you have any of the following conditions*

☐ Diabetes

Type 1 or 2?: _____ A1C?: _____ Fasting Blood Sugar Level?: _____

Endocrinologist: Endocrinologist Phone Number:

_____ _____

- *If monitored by PCP listed previously, please check here* ☐

☐ High Blood Pressure	☐ Elevated Cholesterol	☐ Arthritis
☐ Cancer (specify below)	☐ Thyroid Disorder (specify below)	☐ Migraines
☐ Neurological Disorder	☐ Herpes Simplex/Zosters	☐ HIV/AIDS
☐ Asthma	☐ Psychiatric/Depression	☐ Pregnant
☐ Respiratory Disorder (specify below)	☐ Ear/Nose/Throat	
☐ Muscular/Skeletal	☐ Seasonal Allergies	

☐ **No Known Health Conditions**

Other (Please Explain)

_____

_____

5. *Do you have any allergies other than seasonal?*

_____

6. *Please list all medications and dosage:*

Name of Medication	Dosage

- *If you have a physical list of medications and would like us to make a copy instead of listing them above, please let the staff know.*

7. *Do you use any of the following?*

☐ Alcohol ☐ Tobacco ☐ Social Drugs

☐ None

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Optomap Retinal Imaging

Optomap Retinal Exam, an ultra-widefield retinal examination, is the revolutionary diagnostic tool that allows clinicians to view a majority of the retina. The Optomap Retinal Exam is a **non-dilating** camera that captures a digital image of the retina. The Optomap allows the doctor to capture a 200° high-resolution image of the retina in a single shot—**without dilation** -- in a quarter of a second. It's easy for the patient, takes just a few minutes to perform, and is immediately available for review with the patient in the exam room.

What can the Optomap® detect?

Both ocular and systemic disease can be detected with the Optomap. The device allows us to evaluate your retina for problems such as macular degeneration, retinal holes, retinal detachments, hypertension and diabetic retinopathy. Benign nevi or "freckles" of the back of the eye can also be found just like freckles on your skin. A device like the Optomap is critical to differentiate benign "freckles" versus malignant melanomas of the retina. The Optomap allows you the opportunity to see the inside of your eye just as the doctor sees it!

Drs. Coughlin, Bui, and Yager recommend Optomap retinal imaging because:

- It allows for enlargement of image to see more detailed view of the retina
- It takes just a few minutes start-to-finish, a much shorter office visit than if dilation is performed
- You leave the office with vision intact, rather than with light-sensitivity and blur
- Creates a permanent record
- Allows for future comparisons--we can compare this year's image to next year's image—side by side
- Can be reviewed by other doctors, if necessary

The Optomap is covered by some insurance. If not covered, the out of pocket cost to the patient is a **co-payment of $39.**

Please initial below to indicate your preference on this visit today.

_____ I would like to have the Optomap Imaging in lieu of dilation

_____ I would like to decline Optomap Imaging. I realize that my eyes may be dilated by the doctor if necessary.

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Thank you for choosing Bay Hill Eye Care, where your health and safety is our primary focus. The AAO, AOA, and other ophthalmology and optometry specific sources continue to share and update information regarding patient care, signs, symptoms, and the ongoing efforts to understand and control the spread of COVID-19. To help protect our patients and staff against the spread of COVID-19, please answer the following questions:

1. Have you or anyone in your household had a fever in the last three(3) days, respiratory symptoms (cough and shortness of breath), flu-like symptoms, or have been in contact with anyone with a confirmed case of COVID-19? **YES**____ **NO**___
2. Other than healthcare professionals working in patient care, are you currently providing care for anyone who has been diagnosed with COVID-19, had a fever, cough, difficulty breathing or flu-like symptoms in the last 2 weeks? **YES**___ **NO**___
3. Have you travelled internationally in the last 2 weeks? **YES**_____**NO**___
4. Are you or anyone in your household under voluntary or involuntary quarantine in the last 2 weeks? **YES**____ **NO**___
5. Have you or anyone in your household traveled to an area with community spread of COVID-19 in the last 14 days? **YES**__ **NO**___

We are practicing all preventative measures put forth by the Centers for Disease Control, including the use of alcohol and bleach-based disinfectants that are commonly used by Optometrists and Ophthalmologists to disinfect our instruments and office furniture. The same disinfection practices already used to prevent office-based spread of viruses are happening before and after every patient encounter and appreciate your understanding of our new social distancing protocols at this time.

Patient Signature_____Date_____