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I will truthfully answer all the following questions to the best of my knowledge. Spaces left blank will be understood (or interpreted) to mean "NO" or "negative".

Patient Signature (parent/guardian for minor) _____DATE _____

What is the reason for today's visit? _____

EYE HISTORY

- ☐ Glasses
- ☐ Contact Lenses
- ☐ Cataract
- ☐ Corneal problems
- ☐ Glaucoma
- ☐ Strabismus (crossed eyes)
- ☐ Retinal Detachment
- ☐ Eye Injury
- ☐ Macular Degeneration
- ☐ Diabetic retinopathy
- ☐ Laser Eye surgery
- ☐ Other eye surgery:

_____

MEDICAL HISTORY

- ☐ Diabetes, if so how long _____
- ☐ Cancer, if so what type _____
- ☐ High Blood Pressure
- ☐ HIV/AIDS *VIH/SIDA*
- ☐ Thyroid disease
- ☐ Anemia/Sickle Cell
- ☐ Migraine
- ☐ Sleep Apnea
- ☐ History of taking Flomax
- ☐ Use of steroids
- ☐ Raynaud's phenomenon
- ☐ Prior hemorrhage/blood transfusion
- ☐ Other medical history not listed above:

_____
_____
_____

SOCIAL HISTORY: > 16 year old

- ☐ Single
- ☐ Married
- ☐ I live alone
- ☐ I drive
- ☐ Alcohol use
- ☐ Marijuana use
- ☐ History of IV drug use
- ☐ Never Smoker
- ☐ Past Smoker, quit _____
- ☐ Current Smoker

_____cigarettes/day

SOCIAL HISTORY--<16 year old

- ☐ Lives with: _____
- ☐ Favorite activity: _____
- ☐ Grade in school: _____

FAMILY HISTORY

☐ Eye problems (cataract, glaucoma, corneal problems, crossed eyes, macular degeneration):

_____
_____

☐ Diabetes ☐ High Blood Pressure ☐ Other family medical issues_____

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Primary Care Physician/Address_____

Referring physician /Address _____

Last Eye Exam (Date/Doctor/Location)_____

Preferred Pharmacy/Address/Phone Number _____

PEDIATRICS ONLY

Immunizations up to date? ☐ Yes ☐ No

Premature birth? ☐ Yes ☐ No

Birth weight _____

Gestational age _____

FOR TESTING PURPOSES

Height _____

Weight _____

Metal in body? _____

ALLERGIES ☐ Allergies already documented in Cerner ☐ No allergies ☐ Latex allergy

Allergy	Reaction

MEDICATIONS ☐ Medications already documented in Cerner ☐ Medication list attached ☐ No medications

Medication name	Dose	How Often	Last dose Date/Time

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Refraction (Exam for glasses)

Your medical insurance usually covers an eye examination based on your visual complaints and a medical diagnosis. However, very few medical insurance plans cover a "refraction" to determine whether your vision can be improved with glasses.

A refraction is used as a medical tool to help determine if there is any vision loss and whether or not it is related to a medical condition. We will bill your insurance $25.00 for this service. However, if it is not covered by your insurance, you will be responsible for payment.

I have read the above information and understand that refraction is a non-covered service. I accept full financial responsibility for the cost of this service. My co-payment is separate from and not included in the refraction fee.

This notice is good for one year from the date signed.

_____ _____

Patient Signature (parent/guardian for minor) *Date*

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ADULT If the patient is 18 years of age or older, please fill out the following.

General Health

- ☐ No problems
- ☐ excessive weight loss/gain
- ☐ change in appetite
- ☐ fevers /chills
- ☐ excessive sweating
- ☐ weakness/fatigue
- ☐ Other_____

Head/Ear/Nose/Throat

- ☐ No problems
- ☐ headaches
- ☐ hearing problems
- ☐ ringing in ears
- ☐ ear infections or pain
- ☐ vertigo/diziness
- ☐ tooth ache/dental problems
- ☐ bleeding from the gums or nose
- ☐ throat pain/difficulty swallowing
- ☐ Other: _____

Respiratory/Breathing Problems

- ☐ No problems
- ☐ cough
- ☐ wheezing/asthma
- ☐ cough producing sputum or blood
- ☐ frequent colds/cough
- ☐ Other: _____

Cardiovascular System

- ☐ No problems
- ☐ high blood pressure
- ☐ fainting
- ☐ ankle/leg swelling
- ☐ palpitations or rapid heart beat
- ☐ heart mumur
- ☐ heart attack
- ☐ difficulty breathing when lying flat
- ☐ rheumatic fever
- ☐ chest pain
- ☐ Other: _____

Gastrointestinal

- ☐ No problems
- ☐ excessive nausea/vomiting
- ☐ blood in the stools or dark tarry stools
- ☐ change in bowel habits
- ☐ Other: _____

Genital/Urinary

- ☐ No problems
- ☐ pain with urination
- ☐ frequent urination
- ☐ blood in the urine
- ☐ discharge or sores in the genital area
- ☐ Other:_____

Musculoskeletal

- ☐ No problems
- ☐ arthritis
- ☐ joint pains
- ☐ Other: _____

Skin

- ☐ No problems
- ☐ rashes /hives
- ☐ easy bruising
- ☐ Other:_____

Neurological/Psychiatric

- ☐ No problems
- ☐ weakness/numbness on one side of the body
- ☐ seizures
- ☐ loss of consciousness or stroke
- ☐ psychiatric problems
- ☐ depression
- ☐ Other: _____

Endocrine

- ☐ No problems
- ☐ unsual heat or cold sensitivity
- ☐ change in voice/hair
- ☐ diabetes
- ☐ Other: _____

Place patient label here if available Name*:* Date of Birth: MR #: Today's Date*:*	VCU Medical Center MCV Hospitals and Physicians Richmond, Virginia 23298 Ophthalmology

PEDIATRIC For patients under 18 years of age, please fill out the following and write any explanations in the space provided.

YES NO Birth History

the patient was born premature ☐ full term ☐
☐ ☐ pregnancy complications?
☐ ☐ Other:_____

General Health

☐ No problems
☐ excessive weight loss/gain
☐ change in appetite
☐ fevers /chills
☐ weakness/fatigue
☐ Other:_____

Head/Ear/Nose/Throat

☐ No problems
☐ headaches
☐ hearing problems
☐ ear infections or pain
☐ bleeding from the gums or nose
☐ teeth problems
☐ Other: _____

Respiratory/Breathing Problems

☐ No problems
☐ cough
☐ wheezing/asthma
☐ frequent colds/cough
☐ Other: _____

Neurological/Developmental

☐ No problems
☐ Attention deficit disorder
☐ behavioral problems
☐ seizures
☐ developmental delay
☐ speech difficulties
☐ reading difficulties/delays

Does the child receive therapy?

☐ PT ☐ OT
☐ speech therapy
☐ vision therapy

☐ Other:_____

Yes No
☐ ☐ Has your child ever been hospitalized?
If yes,explain_____
_____

Gastrointestinal

☐ No problems
☐ frequent nausea/vomiting
☐ diarrhea /constipation
☐ abdominal pain
☐ bloody bowel movements
☐ Other: _____

Genital/Urinary

☐ No problems
☐ frequent urination
☐ blood in the urine
☐ urinary infection
☐ Other:_____

Musculoskeletal

☐ No problems
☐ muscle pains
☐ joint pains
☐ abnormal walking
☐ curved spine (scoliosis)
☐ broken bones
☐ swollen glands
☐ twisting of the neck (torticollis)
☐ Other: _____

Skin

☐ No problems
☐ rashes /hives
☐ easy bruising
☐ Other:_____

Cardiovascular System

☐ No problems
☐ shortness of breath or difficulty breathing
☐ irregular or fast heart beat
☐ fainting
☐ "spells of turning blue" (Cyanosis)
☐ Other:_____

Contagious Diseases: during the last 30 days has your child been exposed to any contagious disease (measles, chicken pox, etc.)?

☐ No ☐ Yes
If yes, list: _____