

D'Alonzo Family Eye Care
420 North Springfield Road, Clifton Heights, PA 19018
Medical Questionnaire

Name: _____ Date of Birth: _____

Occupation: _____ Primary Care Doctor: _____

Today's Date: _____ Reason for Visit: _____

Preferred Method of Communication (Please circle): Phone Call Text E-Mail

Phone Number and/or E-Mail Address: _____

Health Insurance Information:

Vision Plan: _____ I.D. # _____

Medical Insurance: _____ I.D. # _____

Do you currently:

Wear glasses? _____ How old are your glasses? _____

Wear contact lenses? _____ Type of contact lenses? _____

(Please note: Contact lens evaluation is separate from exam fee)

Are you interested in learning more about refractive eye surgery (including LASIK)?

Yes _____ No _____

As part of your routine eye exam, your optometrist will perform a **Computerized Visual Field Analysis** that is not typically covered by insurance. This is a test of your peripheral vision that can help detect strokes, tumors, aneurysms, glaucoma, and other conditions. The cost of this screening is \$25.

Additionally, the doctor recommends a new optional medical screening test called the **i-Wellness O.C.T. Retinal Scan**. This allows for 3D imaging of the layers of the retina to detect early changes from diabetes, macular degeneration, glaucoma, and other conditions. It is quick, painless, and non-invasive. The cost is \$29. Please indicate below if you are interested in receiving this screening at today's appointment.

Yes _____ No _____ Please Give Me More Information _____

**** PLEASE COMPLETE BACK PAGE ****

Do you ever experience any of the following symptoms? (Check all that apply)

- Blurred vision (even with glasses or contact lenses on)
- | | | |
|-----------------------------------|---|--|
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Burning/stinging | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Sandy/gritty feeling | <input type="checkbox"/> Light sensitivity |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Dryness | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Other: _____ |

Please list any previous eye injuries, infections, or surgeries:

Have you ever been diagnosed with any of the following conditions? (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Degeneration |

****Please inform your doctor if you are currently pregnant or nursing****

Please list any other medical conditions:

Please list any current medications:

Do you have any allergies to medications?

Yes (Please list) _____ No _____

Do you have a family history of any of the following conditions?

- | | | | |
|--------------------------|-----|----|------------|
| 1) Diabetes: | Yes | No | Who? _____ |
| 2) Glaucoma: | Yes | No | Who? _____ |
| 3) Macular Degeneration: | Yes | No | Who? _____ |

Patient Signature: _____