INFORMED CONSENT OR REFUSAL FOR A DILATED FUNDUS EXAM

In order to provide the most comprehensive exam possible we request that all of our patients have a dilated eye exam. At least 60% of the retina cannot be viewed without dilation. The purpose is to enlarge the pupils to enhance the detection of any ocular diseases such as cataracts, glaucoma, retinal disease, malignant growth, and retinal detachment; all of which can lead to vision loss. In addition, some systemic conditions such as diabetes and hypertension can cause changes in the health of the eye and can be detected by dilation.

Possible side effects (**these side effects typically do not last longer than 4-6 hours**):

- Inability to focus at near
- Sensitivity to light
- Blurry distance vision for some patients
- Mild burning upon instillation
- Induced ocular hypertension: RARE cases have been reported in which redness and sharp pain is experienced because of increased eye pressure. If this happens, contact the doctor immediately.

Please Check One Box:

☐I understand the above and consent to have dilation done.

☐ I understand the above and decline dilation at this time. I understand that potential for partial or total loss of vision may exist and, without dilation, may go undetected.

Signature:_____ **Date**:_____

Medical History/ Social History

Are you Pregnant or Nursing? ☐Yes☐No **Are you Diabetic?** ☐Yes☐No **Have you had refractive surgery?** ☐Yes☐No

Are you Allergic to any medications ☐Yes ☐No, **if yes, explain**_____

List Current Medications:_____

List major injuries/surgeries/hospitalzations:_____

List any Eye Surgeries:_____

Last Eye Exam:_____ **Last Medical Exam**:_____

Do you wear glasses ☐Yes ☐No **Do you wear contact lenses** ☐Yes ☐No **If yes, what type:** ☐Soft ☐Rigid

Your contact lens brand/RX_____**Would you like to be fitted for contacts today** ☐Yes ☐No

Do you use tobacco products? ☐Yes☐No **If yes, type/amount/how long**_____ **Have you been exposed or infected with:**

Do you drink alcohol? ☐Yes☐No **If yes, type/amount/how long**_____ ☐***Gonorrhea*☐***Hepatitis*☐***HIV*☐***Syphilis***

Family History:

Ocular/Systemic Conditions	Family Member Affected (Maternal/Paternal)
☐Blindness due to Disease	
☐Blindness due to Injury	
☐Glaucoma	
☐Macular Degeneration	
☐Retinal Detachment	
☐Retinal Degeneration	
☐Arthritis	
☐Cancer ▫Type:	
☐Diabetes	
☐Heart Disease	
☐Hypertension	
☐Kidney Disorder	
☐Thyroid Disease	
☐Other:	

***If none of the above apply please initial here _____**

Patient History/Review of Systems

Cardiovascular ☐Heart Disease ☐Elevated Cholesterol ☐High Blood Pressure	**Lymphatic/ Hematologic** ☐Anemia ☐Coagulation Disorder ☐Leukemia	**Musculoskeletal** ☐Arthritis ☐Muscle Pain ☐Joint Pain ☐Rheumatoid arthritis	**Integumentary (Skin)** ☐Lupus ☐Psoriasis ☐Eczema
Gastrointestinal ☐Diarrhea ☐Constipation	**Respiratory** ☐Asthma ☐Bronchitis ☐Emphysema	**Endocrine** ☐Diabetes Insipidus ☐Diabetes Mellitus ☐Thyroid Dysfunction	**Psychiatric** ☐ADD/ADHA ☐Anxiety ☐Depression
Constitutional ☐Fever ☐Weight Gain ☐Weight Loss	**Genitourinary** ☐Kidney Problems ☐Bladder Problems **Neurologic** ☐Seizures ☐Multiple Sclerosis ☐Headaches ☐Migraines	**Ears/Nose/ Throat** ☐Chronic Cough ☐Dry Mouth ☐General Allergies ☐Head Colds	**Eyes** ☐Crossed Eyes ☐Lazy Eye ☐Glaucoma ☐Retinal Disease ☐Retinal Detachment ☐Cataract ☐Other _____

Ocular History/Review of Systems

***If none apply please initial here_____**

☐Blurry Vision ☐Double Vision ☐Dryness ☐Redness
☐Itching ☐Burning ☐Eye Pain ☐Light Sensitivity
☐Watery Eyes ☐Eye Fatigue ☐Flashes ☐Floaters

***If none of the above apply please initial here ____**

Please note any other medical or ocular conditions not listed _____