COVENTRY EYE CARE ASSOCIATES, LTD.

RETINAL WELLNESS AND MACULAR HEALTH RISK SCREENINGS

We take pride in offering advanced eye care technology. Market research tells us that patients want technology that helps detect any vision threatening conditions regardless of age. We recommend two areas to be screened. One is the entire retina which the Optos screening can only provide. The other is the macula which provides your straight ahead, color and detailed vision. Today macular degeneration and dystrophies are a major area of concern. When neurological damage is detected, early treatment may be possible to prevent blindness.

Two conditions which require the procedures to be performed are:

1) Diabetes, which is a leading cause of blindness and risk of damage to the macula.
2) Pregnancy, since dilation drugs are not recommended for pregnant persons.

___DIGITAL RETINAL IMAGING/OPTOS (47.00)*

This provides a magnified view of the entire retina and promotes early diagnosis of abnormal conditions which could prevent permanent vision loss. An additional benefit is that the images are permanently stored and are able to be compared against future retinal scans. ***For patients who have pathology, this procedure will be billed medically and the charges will be dictated by your insurance.**

___OPTICAL COHERENCE TOMOGRAPHY(OCT) (10.00)

We advise the OCT screening to detect, prevent, and treat macular degeneration, retinal holes, and detect early signs of glaucoma.

I UNDERSTAND THAT IF I CHOOSE NOT TO HAVE THE DIGITAL RETINAL SCANNING PERFORMED I WILL BE DILATED TODAY TO EVALUATE MY RETINAL HEALTH.

SIGNATURE. _____ DATE _____

Medical History Questionnaire

*For returning patients ***without*** an eye exam within the past 3 years*

Name: _____ Today's Date: ____ / ____ / _____

Address: _____ Phone: _____

City: _____ Zip: _____ Work Phone : _____

Guardian (If Applicable):_____ Occupation: _____

Birth Date: ____ / ____ / ____ SS#: _____ Last Eye Exam: ____ / ____ / _____

Name of Medical Doctor: _____ Dr's Phone: _____

Last Eye Exam: ____ / ____ / _____

Medical History

Do you have any allergies to medications?

__ No

__ Yes , explain: _____

List any medication you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had:

_____

_____

List any of the following you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

_____

Are you pregnant and/ or nursing? __ No __ Yes

Do you wear glasses? __ No __ Yes If so, how old is your present pair of lenses?

_____

Do you wear contact lenses? __ No __ Yes If so, how old is your present pair of lenses?

_____

Type of contacts __ Rigid __ Soft __ Extended Wear __ Other

Are they comfortable? __ No __ Yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Yes	?	Relationship to You
Blindness	__	__	__	_____
Cataract	__	__	__	_____
Crossed Eyes	__	__	__	_____
Glaucoma	__	__	__	_____
Macular Degeneration	__	__	__	_____
Arthritis	__	__	__	_____
Cancer	__	__	__	_____
Diabetes	__	__	__	_____
Heart Disease	__	__	__	_____
High Blood Pressure	__	__	__	_____
Kidney Disease	__	__	__	_____
Lupus	__	__	__	_____
Thyroid Disease	__	__	__	_____
Other _____	__	__	__	_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

__ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? __ No __ Yes If yes, do you have visual difficulty while driving? __ No __ Yes

If yes, please describe: _____

Do you use tobacco products? __ No __ Yes If yes, type/amount/how long: _____

Do you drink alcohol? __ No __ Yes If yes, type/amount/how long: _____

Do you use illegal drugs? __ No __ Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infection with: __ Gonorrhea __ Hepatitis __ HIV __ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
CONSTITUTIONAL				**EARS, NOSE THROAT**			
Fever, weight Loss / Gain	__	__	__	Allergies / Hay Fever	__	__	__
INTEGUMENTARY (Skin)	__	__	__	Sinus Congestion	__	__	__
NEUROLOGICAL				Runny Nose	__	__	__
Headaches	__	__	__	Post-Nasal Drip	__	__	__
Migraines	__	__	__	Chronic Cough	__	__	__
Seizures	__	__	__	Dry Throat / Mouth	__	__	__

	NO	YES	?
EYES			
Loss of Vision	__	__	__
Blurred Vision	__	__	__
Distorted Vision / Halos	__	__	__
Loss of Side Vision	__	__	__
Double Vision	__	__	__
Dryness	__	__	__
Mucous Discharge	__	__	__
Redness	__	__	__
Sandy or Gritty Feeling	__	__	__
Itching	__	__	__
Buring	__	__	__
Foreign Body Sensation	__	__	__
Excess Tearing / Watering	__	__	__
Glare / Light Sensitivity	__	__	__
Eye Pain or Soreness	__	__	__
Chronic Infection or Eye or Lid	__	__	__
Sties or Chalazion	__	__	__
Flashes / Floaters	__	__	__
Tired Eyes	__	__	__
ENDOCRINE			
Thyroid / Other Glands	__	__	__
ALLERGIC/IMMUNOLOGIC	__	__	__

	NO	YES	?
RESPIRATORY			
Asthma	__	__	__
Chronic Bronchitis	__	__	__
Emphysema	__	__	__
VASCULAR / CARDIOVASCULAR			
Diabetes	__	__	__
Heart Pain	__	__	__
High Blood Pressure	__	__	__
Vascular Disease	__	__	__
GASTROINTESTINAL			
Diarrhea	__	__	__
Constipation	__	__	__
GENITOURINARY			
Genitals/Kidney/Bladder	__	__	__
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	__	__	__
Muscle Pain	__	__	__
Joint Pain	__	__	__
LYMPHATIC / HEMATOLOGIC			
Anemia	__	__	__
Bleeding Problems	__	__	__
PSYCHIATRIC	__	__	__

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature Date