THE FOLLOWING WILL ASSIST THE DOCTOR IN YOUR EXAMINATION

Date:___________ PCP:___________________________ New Update

Legal Last Name:	Legal First Name:	MI:	Name to be addressed by staff:

Street Address:	Apt #	City, State	Zipcode

Email Address:	Please circle one below:
	Widowed Married Single Divorced

Gender:	Date of Birth:	Social Security:	Day Phone:	Home Phone:
M F				

Place of Employement:	Occupation:

Referred by: □Patient:___________________________ □Doctor:____________________________
□Yellow Pages □Newspaper □Insurance □Other:__________

In case of emergency, contact: Name:_____________________ Day Phone:_______________
If minor, **who is responsible for the account?** Name:____________________ Day Phone:____________

Name of Primary on Insurance:___________________ DOB:_______________ S.S.#_______________
Place of Employement:_____________________________________ Phone:_______________________
Medical Insurance: ______________________ ID#____________________ Grp#_______________
Vision Insurance: ______________________ ID#____________________ Grp#_______________

1. Date of Last Exam: __________________________ By Dr.___________________________
2. Are you allergic to ANY medications, foods, dyes, etc? If so, please list reaction:
____
____

3. List ALL medications you are taking, including over the counter drugs (includes vitamins):____
____

4. List ALL surgeries that you have had (cataract, appendectomy, etc.) and approximate date:____
____

5. List ALL major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) and approximate date:____
____

6. Do you smoke? □Yes □No Frequency:___________________________
7. Do you drink? □Yes □No Frequency:___________________________

8. Please tell us of any problems you are having with your eyes today:____
____

9. Do you currently wear glasses? □Yes □No
10. Do you currently wear contact lenses? □Yes □No
10a. If applicable what brand of contacts are you wearing? ______________________________
11. Are you interested in contact lenses? □Yes □No
12. Are you interested in a Lasik consultation? □Yes □No

13.

Eyes	**Yes**	**No**	**If yes, state when symptoms started**
Loss of Vision			
Blurred Vision			
Fluctuating Vision			
Distorted Vision			
Dryness			
Loss of Side Vision			
Mucous Discharge			
Redness			
Sandy or Gritty Feeling			
Itching or Burning			
Feeling of something in eye			
Excess Tearing			
Light or Glare Sensitivity			
Eye pain or soreness			
Infection of eye or eyelid			
Tired Eyes			
Crossed Eye or Lazy Eye			
Droopy Eyelid			
Flashes of Light in Vision			
Floaters in Vision			
Other			

14.

Family History	Yes	No	Please state which family member
Disease			
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Heart Attack			
Thyroid Disease			
Other			

ANNUAL RETINAL EVALUATION

Retinal problems, including macular degeneration, glaucoma, retinal holes or detachments and systemic conditions can lead to serious health problems. Partial loss of vision or blindness can often develop without warning and progress with no symptoms. Dr. Hannigan is proud to announce the inclusion of the OptoMap retinal exam as an integral part of your eye exam. Please check the method you wish to authorize for today's visit:

☐ Dilation (traditional form, covered by vision plans)

☐ OptoMap (this new technology requires NO dilation and is the newest in technology for retinal checks. Currently, only covered by medical insurance and not vision plans. Fee for the OptoMap is $35.

☐ No dilation or OptoMap

Signature: ____ Date: ____________________