Fernando A. Romero, MD, PA
Pediatric & Adult Ophthalmology

ACTIVITY OF DAILY LIVING

Patient Name: ____

PLEASE CIRCLE YOUR RESPONSE ON EACH LINE
(Please leave blank if it does not apply)

Have you been bothered by:	Answer		Comments	
Overall decline in vision	YES	NO		
Blurry Vision	YES	NO		
Glare or poor night vision	YES	NO		
Sensitivity to light	YES	NO		
Seeing rings or halos around lights	YES	NO		
Seeing double	YES	NO		

Have you noticed a decrease in your vision when you:	Answer		Comments	
Drive during daylight hours	YES	NO		
Drive during nighttime hours	YES	NO		
See traffic or road signs	YES	NO		
Read newspapers or telephone books	YES	NO		
Read labels, price tags or medicine bottles	YES	NO		
Use a computer	YES	NO		
Do fine handwork or hobbies	YES	NO		
Look at colors	YES	NO		
Seeing crossword puzzles	YES	NO		
Play cards	YES	NO		
Watch TV	YES	NO		
Look out of only one eye	YES	NO		
Other				

Patient's Signature: ______________________________**Date:**______________

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Vision and Medical Eye Visit Check-in

PATIENT NAME (printed): ____

A. Patient Visit Types:

- **Medical Eye Exam:**
  These are examinations for diagnosis and treatment of eye diseases. If glasses or contact lenses cannot improve vision, often the cause is related to an underlying medical eye condition. This exam requires dilation of your eyes. Follow-up medical eye exams scheduled throughout the year may not require dilation.

- **Refraction:**
  Refraction is the optical determination of the best possible corrected vision. It is needed to determine if any medical, optical, or surgical treatment may be indicated. It is NOT a covered service by most medical insurance plans. **Our office fee for a refraction is** $ 75.00 and it is collected at the time of service and is in addition to any medical insurance co-payment.

- **Vision Eye Exam (Routine Visit):**
  These examinations (not performed by the ophthalmologist) determine if vision can be improved with glasses and may help identify eye diseases. This visit may or may not require dilation of your eyes. This type of exam is not available for established patients who have diagnosed eye disease or other medical condition that affects the eyes' health.

B. Please check below and sign for the type of exam you are have scheduled for today:

☐ **Medical Eye Exam** ☐ **Refraction** ☐ **Routine Vision Eye Exam**

______________________________ ______________________________
Patient Signature **Date**

C. Refraction Notice to Patients

Refraction must be performed in order to obtain a prescription. Do you want to receive an eyeglasses prescription today?

☐ **Yes** ☐ **No** **Patient's initials:** _________

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INTERIM MEDICAL HISTORY

Date___________________________

Name____ Date of **last eye exam**____________________

What **medications** (Rx & OTC) have you added or discontinued since your last visit?

____

Do you have any ***new*** **allergies** to medications since your last visit? _____YES _____NO
If YES, list the medications:

____

Have you had any **major illnesses** or **injuries** since your last visit?

____

Have you had any **surgeries** since you last visit?

____

Do you ***currently*** have any problems in the following areas? If "YES" , Please provide information.

	YES	NO	Explanation of problem
EYES			
GENERAL / CONSTITUTIONAL			
EARS, NOSE, THROAT			
CARDIOVASCULAR			
RESPIRATORY			
GASTROINTESTINAL			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS			
SKIN			
NEUROLOGICAL			
PSYCHIATRIC			
ENDOCRINE			
BLOOD, LYMPH			
ALLERGIC, IMMUNOLOGIC			

FAMILY

Any changes to family medical status (mother, father, sibling, grandparent)? _____YES _____NO
If YES, describe____

SOCIAL

Changes in employment?____
Marital Status (married, divorced, single, widowed)____
Living arrangements____
Do you drive? _____YES _____NO
Do you have visual difficulty when driving? _____YES _____NO
Do you have problems with night vision? _____YES _____NO
Do you drink alcohol? _____YES _____NO If YES: occasional 1 per day 2-3 / day 4+ / day
Do you smoke? _____YES _____NO If YES: occasional ½ pack/day 1 pack/day 1+ pack

Physician's Signature____