Patient Name: _____ DOB: _____ Today's Date: _____
Parent or Legal Guardian's Name (if the patient is <18yo): _____
Full Address: _____ SSN: _____
Race: _____ Sex: _____ Occupation: _____
Cell#: _____ Email: _____
Primary Care Physician (if have one): _____ Phone: _____
Preferred Pharmacy (if have one): _____ Phone: _____

1. Briefly, what is the reason for your visit today?

2. Check any health issue and/or systemic surgeries you have had & indicate when:
   ☐I was at Omni Vision before and there is NO change
   ☐NONE ☐Cholesterol ☐Blood Pressure ☐Diabetes type 1 or 2
   ☐Others, please list:

3. Check any eye disease and/or eye surgeries you have had & indicate when:
   ☐I was at Omni Vision before and there is NO change
   ☐NONE ☐Dry eyes ☐Cataracts ☐Glaucoma ☐LASIK or PRK
   ☐Others, please list:

4. List any eye medication (with dosage) you are currently taking:
   ☐I was at Omni Vision before and there is NO change
   ☐NONE ☐YES, please list:

5. List any medication (with dosage) you are currently taking by mouth:
   ☐I was at Omni Vision before and there is NO change
   ☐NONE ☐YES, please list:

6. List any Allergies and Reactions:
   ☐I was here before and there is NO change
   ☐NONE ☐YES, please list:

7. Do you smoke?
   ☐Never ☐Yes, in the past ☐Yes currently, if so How much:

8. Do you drink?
   ☐Never ☐Yes, in the past ☐Yes currently, if so How much:

9. Check any eye diseases your parents or siblings have had and indicate who:
   ☐I was at Omni Vision before and there is NO change
   ☐NONE ☐Cataracts ☐Glaucoma ☐Macular Degeneration
   ☐Others, please list:

10. Check any health issue your parents or siblings have had and indicate who:
    ☐I was at Omni Vision before and there is NO change
    ☐NONE ☐Cholesterol ☐Blood Pressure ☐Diabetes type 1 or 2
    ☐ Others, please list:

OMNI VISION
RETINAL EXAMINATION NOTICE

A retinal examination is a part of a thorough eye examination. It is the standard of care and recommended to be done yearly. It allows our doctor to evaluate the back of your eyes, including your retina, optic disc and the underlying layer of blood vessels. Several eye diseases and conditions are detected at their earliest stages during a thorough retinal eye examination.

Please let us know if you are: pregnant, breastfeeding your newborn, or allergic to eye drops.

Here are 2 options for your retinal examination. CIRCLE OPTION#1 or OPTION#2 and SIGN!

Our doctors recommend this latest technology for your eyes

	OPTION #1 **Retinal Imaging** (picture of the back of your eyes)	**OPTION #2** **Dilation Eye Drops**
EYE DROPS?	NO	YES
VISION AFFECTED?	NO	YES blurry vision & light sensitivity (Average duration ~5 hours)
WAITING TIME?	NONE	YES ~15-30 minutes for drops to dilate eyes
FEE?	**$39.00 extra** (Insurance does not cover this fee)	**NONE** (It is included in your exam fee)
NOTE:	The doctor will show you the picture. This is a great option for monitoring changes over the years	Let us know if you strongly think you should not be dilated today

Name: _____

Date: _____ Signature: _____