Panorama OPTOMETRY

Patient Information

Last Name:___________________________________
First Name: __________________________________
Care Card#:___________________________________
Date of Birth:_________________________________
Cell Phone:___________________________________
Home Phone: __________________________________
Email Address:________________________________
Home Address:________________________________
Referred by:__________________________________

Do you have an eyewear benefits program? ☐Y ☐N
How would you prefer to be contacted?

☐EMAIL ☐TEXT ☐CALL

Is it okay to email you to update you on your appointments, newsletters and events? ☐Y ☐N
What is the purpose of this visit?__________________
____
Any problems with your current contact lenses or glasses?_________________________________
____
Date of last eye exam? ______________________

Patient Eye History

Do you currently wear glasses? ☐Y ☐N

Do you currently wear contacts? ☐Y ☐N

Planning to update your glasses? ☐Y ☐N

Would you like the doctor to check your current contact lenses health and fit today? ☐Y ☐N

Are you satisfied with the….

Vision with the contacts? ☐Y ☐ N

Comfort with contacts? ☐Y ☐N

If you no longer wear contact lenses, why did you discontinue their use? ___________________________

Have you experienced, been diagnosed or treated for any of the following?

- ☐ Amblyopia (lazy eye)
- ☐ Blurry distance vision
- ☐ Cataract
- ☐ Double vision
- ☐ Eye infection
- ☐ Flashes of light
- ☐ Glaucoma
- ☐ Headache
- ☐ Itchiness
- ☐ Retinal Detachment
- ☐ Sunlight Sensitivity
- ☐ Blurry near vision
- ☐ Burning sensation
- ☐ Corneal Disease
- ☐ Dry eye
- ☐ Eye Injury
- ☐ Floaters/spots
- ☐ Grittiness
- ☐ Iritis/Uveitis
- ☐ Macular degeneration
- ☐ Strabismus
- ☐ Tearing
- ☐ Trouble seeing at night
- ☐ Uncomfortable glasses
- ☐ Other eye disorders?

____
____

Please list any eye surgeries you have had.

Year	Surgery	Surgeon

____
____

CURRENT MEDICATIONS (RX or Over the Counter)
(List names of medications including eye drops, vitamins, & birth control pills

Patient Medical History

1. ____
2. ____
3. ____
4. ____

Please list any environmental and medication allergies:
____
____

Do you smoke? ☐Y ☐N

Have you even been diagnosed or treatment for the following?

	Yes	No
Acid reflux	☐	☐
Arthritis	☐	☐
Arrhythmia	☐	☐
Cancer	☐	☐
Cholesterol/dyslipidemia	☐	☐
Diabetes	☐	☐
Eczema/Rashes	☐	☐
Heart disease	☐	☐
High Blood Pressure	☐	☐
Hypothyroid	☐	☐
Migraines	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Traumatic Brain Injury	☐	☐
Vertigo	☐	☐
Other health problems:	☐	☐

____
____

Family History

Is there a family medical history of any of the following: Please indicate relationship (IE: Maternal Grandmother)

Amblyopia (lazy eye)	☐	____________________
Blindness	☐	____________________
Cataracts	☐	____________________
Corneal disease	☐	____________________
Diabetes	☐	____________________
Glaucoma	☐	____________________
Macular Degeneration	☐	____________________
Retinal Disease	☐	____________________
Strabismus (eye exam)	☐	____________________
Other	☐	____________________
	☐	____________________

Authorization for Release of TBI Patient Information

Patient name: ____

Date of Birth: ____

- ❑ I agree to have my information, or copies of my records released to all professionals related to my health care.

  Name: ____

  Email: ____

  Fax: ____

Or

- ❑ Only release my information to ___________________________________

  Name: ____

  Email: ____

  Fax: ____

This authorization shall be considered valid throughout the duration of treatment.

Signature: ______________________

Date:__________________________