



# Case History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Eye Symptoms

- Blurred Vision(1)
- Night blur(2)
- Double vision(3)
- Itchiness(4)
- Burning/ Dry Eye(5)
- Tearing(6)
- Secretions/Pus(7)
- Redness(8)
- Pain(9)
- Light Sensitivity(10)
- Tired Eyes(11)
- Squinting(12)
- Light Flashes(13)
- Floating Spots(14)
- Eye Strain(15)
- Dizziness(16)

## Personal Medical History

- Diabetes(1)
- High Blood Pressure(2)
- Heart Disease(3)
- High Cholesterol(4)
- Allergies/Hayfever(5)
- Novocaine Allergy(6)
- Drug Allergies(7)
- Sinus Trouble(8)
- Asthma/Emphysema(9)
- Thyroid/Other Glands(10)
- Arthritis/Muscle,Joint Pain(11)
- Stomach/Intestines(12)
- Pregnant or Nursing(13)
- Anemia, Bleeding(14)
- Psychiatric(15)
- Eczema/Melanoma(16)
- Tobacco products
- Alcohol/ Drugs

List Current Medications:

## Personal Eye History

- Disease(1)
- Injury(2)
- Surgery(3)
- Cataracts(4)
- Glaucoma(5)
- Pink Eye(6)
- Other Eye Problems(7)
- Styes(8)
- Crossed Eyes(9)
- Astigmatism(10)
- Color Blindness(11)
- Headache(12)
- Other Problems(13)

## Family Medical History

- Diabetes(1)
- High Blood Pressure(2)
- Cataracts(3)
- Glaucoma(4)
- Blindness(5)
- Color Blindness(6)
- Astigmatism(7)
- Melanoma Cancer(8)
- Arthritis(9)
- Macular Degeneration(10)
- Other(11)

Last eye exam:

## Chief Problems (Current)

Location \_\_\_\_\_

Duration \_\_\_\_\_

Severity \_\_\_\_\_

Modifying Conditions \_\_\_\_\_

Oriented to Person,Time,Place

## Glasses owned:

- Progressive Glasses
- Distance Glasses
- Reading Glasses
- Computer Glasses
- Bifocal Glasses
- Sunglasses
- Safety Glasses
- Sports Glasses
- Music Glasses

## Contact Lens

Do you wear contacts?(even occasionally)  Yes  No

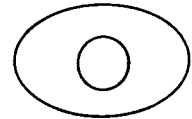
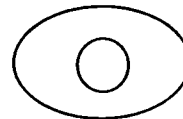
Are you interested in contacts?  Yes  No

Current Contacts: Disposable, Bifocal, GP, Colored

Solutions \_\_\_\_\_

Performance \_\_\_\_\_ Blur: Dx, Int, Nr

## Present Contact Lens Evaluation



CTR \_\_\_\_\_

1° LAG \_\_\_\_\_ mm

Sup LAG \_\_\_\_\_ mm

Surface \_\_\_\_\_

OR \_\_\_\_\_

**Visual Fields**

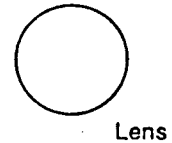
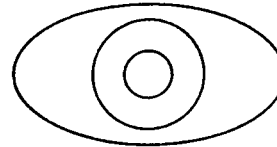
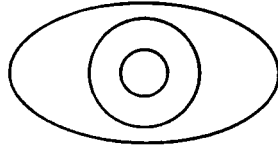
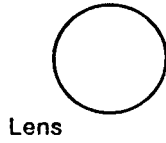
Humphrey/ confrontation

**Dilated Fundus Examination**

pass-fail

pass-fail

**Anterior Segment**



*Lid Margin*  
*Cilia*  
*Lower Tarsus*  
*Lacrimal*  
*Puncta*  
*Conjunctiva*  
*Conj Vessels*  
*Cornea*  
*Endo*  
*Ant. Chamber*  
*Iris*  
*Iris Color*  
*Lens*  
*Angle*  
*Blink Reflex*

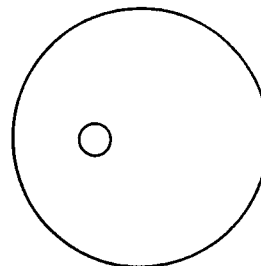
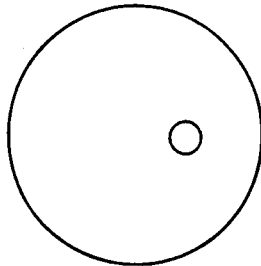
Clear-NC  
 Clear-NC  
 Clear-NC  
 Normal tear-Abn Discharge  
 Open-Closed  
 Clear-NC  
 Normal-Abnormal  
 Clear-NC  
 Clear-NC  
 Clear-NC  
 Clear-NC  
 Brn-BI-Grn-Hzel-Gy  
 Clear-NC  
 X  
 Full-3/4-1/2

Clear-NC  
 Clear-NC  
 Clear-NC  
 Normal tear-Abn Discharge  
 Open-Closed  
 Clear-NC  
 Normal-Abnormal  
 Clear-NC  
 Clear-NC  
 Clear-NC  
 Clear-NC  
 Brn-BI-Grn-Hzel-Gy  
 Clear-NC  
 X  
 Full-3/4-1/2

**Posterior Segment**

- Direct/MIO
- BIO
- 90D

DPA  
 M/C/P/Pmd .5/ 1/ 2.5%  
 M/C/P/Pmd .5/ 1/ 2.5%



*Vitreous*  
*C/D Horiz.*  
*C/D Vert.*  
*Cup Depth*  
*Cup Shape*  
*Disc Margin*  
*Disc Hue*  
*Artery*  
*Veins*  
*A/V Ratio*  
*Macula*  
*Periphery*

Clear-NC  
 1 2 3 4 5 6 7 8 9  
 1 2 3 4 5 6 7 8 9  
 Shallow-Deep\_\_D  
 Distinct-Blurred  
 Pink-Orng-Red-White  
 Normal-Abnormal  
 Normal-Abnormal  
 4/5 3/4 2/3 1/2  
 Clear-NC rflx +/-

Clear-NC  
 1 2 3 4 5 6 7 8 9  
 1 2 3 4 5 6 7 8 9  
 Shallow-Deep\_\_D  
 Distinct-Blurred  
 Pink-Orng-Red-White  
 Normal-Abnormal  
 Normal-Abnormal  
 4/5 3/4 2/3 1/2  
 Clear-NC rflx +/-

**Notes**

Patient Advised: Reason for procedure, possible side effects, photophobia, glare, duration, etc assoc. w/ mydriasis.

# Receipt of Notice of Privacy Policies & Consent Form

**Carlmont Optometry/Dr. Patricia Chang & Associates**

**1019 Alameda de las Pulgas, Belmont, CA 94002 650-594-1019 Fax: 650-594-0158**

**305 Broadway, Millbrae, CA 94030 650-697-2475 Fax: 650-692-7154**

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Patient Name: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our website.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

**I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Carlmont Optometry/Dr. Patricia Chang & Associates.**

\_\_\_\_\_  
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

\_\_\_\_\_  
Relationship to Patient Print Name

Source of Authority: \_\_\_\_\_