



## Wellness Screening Scan and Dilation

Your eyesight is priceless, and we are here to protect it! Annual eye examinations not only allow the doctor to improve the quality of your vision by updating the **prescription** of your glasses or contact lenses, but they also allow her to determine the **overall health** of your eyes from the front (the cornea) to the back of the eye (the retina). Vision-threatening diseases such as glaucoma, age-related macular degeneration, diabetic retinopathy, retinal tears or retinal detachments, and ocular tumors often have no outward signs or symptoms in the early stages, so our practice has begun using state-of-the-art technology to assess the health of your eyes.

**Dr. Clark offers a Wellness Screening Scan to all of her patients. This screening technology**

- \*Is a quick, non-invasive scan that allows our doctor to see and document the inside of the back of your eye**
- \*Involves No Blur, No Dilation, No Light Sensitivity, No Stinging Drops**
- \*Provides a permanent record to compare and track potential eye disease**

As part of your pre-testing, our technician will perform the Wellness Scan which your doctor will review with you during your examination today. The **\$39 charge** is not covered by your vision or medical insurance in most cases, so this will be added into the cost of your visit today.

I have read and understand the benefits of the Wellness Screening Scan. I understand that it is highly recommended by Dr. Clark at Frisco In Focus and is an important part of my comprehensive exam.

\_\_\_\_\_ **I elect to have the recommended Retinal Screening Scan of my retina for \$39.**

\_\_\_\_\_ **I also choose to be dilated.** Dilation gives a wider view of the inside of the eyes and gives the best view of cataracts and retinal holes/detachments. Dilation drops will cause light sensitivity and near blur for a few hours. (Patients with diabetes and certain medical eye complaints must be dilated by Dr. Clark at each medical visit.)

\_\_\_\_\_ **I refuse** to let the doctor look inside my eye using either the Wellness Screening Scan or dilation and understand that I am limiting the doctor's ability to make a timely diagnosis of eye disease. I understand that having 20/20 vision does not guarantee my eyes are healthy. I accept any and all risks of not detecting and delaying treatment of internal eye disease, including permanent loss of vision.

Patient's Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient or Parent's Signature: \_\_\_\_\_

### PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. **Contact lens wearers** – A contact lens and corneal health evaluation is required annually to renew a contact lens prescription. Do you plan to continue contact lens wear and need your contact lens prescription renewed this year? **Yes / No**
2. **Non-contact lens wearers**- Are you interested in learning about contact lens options? **Yes / No**
3. **All Patients**- Do you need to meet with an optician to fill your glasses and/or contact lens prescription today? **Yes / No**

## Medical History Review of Systems Form

Date: _____		Name: _____		Date of Birth: _____	
Address: _____			Email Address: _____		
Occupation: _____		Phone: _____		Primary Care Doctor: _____	
Medical Insurance Co _____	Member Name _____	Member DOB _____	Member ID # _____		

**Do you currently have:**

**Constitution:**

- Developmental Disability
- Cancer
- Fatigue Syndrome

**Ears, Nose, Throat:**

- Hearing Loss
- Sinusitis
- Dry Mouth

**Neurological:**

- Multiple Sclerosis
- Epilepsy
- Tumor
- Migraine

**Psychiatric:**

- Anxiety
- Depression
- Attention Deficit
- Bipolar Disorder

**Cardiovascular:**

- Hypertension
- Stroke
- Heart Disease

**Respiratory:**

- Asthma
- Bronchitis
- Sleep Apnea

**Gastrointestinal:**

- Crohn's
- Ulcerative Colitis
- Ulcer
- Acid Reflux

**Genitourinary:**

- Kidney Disease
- Prostate Disease/Cancer
- Pregnant
- Nursing
- STD

**Musculoskeletal:**

- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Osteoporosis

**Skin:**

- Eczema
- Psoriasis
- Rosacea
- Cold Sores
- Shingles

**Endocrine:**

- Diabetes Type 1
- Diabetes Type 2
- Thyroid Dysfunction

**Hematology/Lymph:**

- Anemia
- High Cholesterol
- Other \_\_\_\_\_

**Allergic/Immunologic:**

- Lupus
- Sjogren's Syndrome

**Ocular:**

- LASIK Surgery: year \_\_\_\_\_
- Cataract Surgery: year \_\_\_\_\_
- Strabismus
- Other \_\_\_\_\_

Tobacco use: Yes /No/Former \_\_\_\_\_/Day

Alcohol use: Yes/No \_\_\_\_\_ Per Day / Week / Month

**Current Medications** (including vitamins): \_\_\_\_\_

**Allergies to Medications:** \_\_\_\_\_

**Family History:**

*Please specify WHO in your Family (Father, Mother, Sister, Brother, Son, Daughter) has these conditions:*

<input type="radio"/> Diabetes Type 1 <b>Family Member:</b>	<input type="radio"/> Cataracts
<input type="radio"/> Diabetes Type 2	<input type="radio"/> Glaucoma
<input type="radio"/> High Blood Pressure	<input type="radio"/> Macular Degeneration
<input type="radio"/> Cancer	<input type="radio"/> Retinal Detachment
<input type="radio"/> Hyperthyroidism	<input type="radio"/> Diabetic Eye Disease
<input type="radio"/> Hypothyroidism	<input type="radio"/> Other