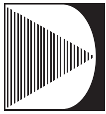

Delaney EyeCare

3325 Main St. • PO Box 636
Birdsboro, PA 19508 • 610-779-2020

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Patient Name ______________________

Address ______________________ City ____________ State ________ Zip ________

If patient is a minor: Grade? ________ Responsible party ______________________

Work phone (______) ______________ Home phone (______) ______________

Email ______________________

Date of birth ______________ Social Security Number ______________

Occupation ______________ Employer ______________

Emergency contact ______________ Phone number (______) ______________

Date of last eye exam ______________ Dilated? Yes / No

Today's date ______________ Referred by ______________

MEDICAL INFORMATION

What is your general health? ______________________

Do you have problems with any of these systems? (Please circle Yes or No)

Gastrointestinal	Yes / No	Nervous	Yes / No	Endocrine (glands)	Yes / No
Ears/Nose/Throat	Yes / No	Urinary	Yes / No	Blood/lymph	Yes / No
Cardiovascular	Yes / No	Muscles/bones	Yes / No	Allergic/immunologic	Yes / No
Respiratory	Yes / No	Integumentary (skin)	Yes / No	Headaches	Yes / No
High blood pressure	Yes / No	Eyes	Yes / No	Mental	Yes / No

Please explain ______________________

Diabetes Yes / No Type ______________ Date of diagnosis ______________

Allergies to medication? Yes / No Which? ______________ Reactions? ______________

Other health problems ______________________

Current medication(s) ______________________ Check if none ☐

Have you had any operations? Yes / No Kind: ______________ When? ______________

Name of family doctor ______________________

Date of last visit ______________ Date of last tetanus shot ______________

FAMILY HISTORY

High blood pressure	Yes / No	Relation	Macular degeneration	Yes / No	Relation
Diabetes	Yes / No	Relation	Retinal detachment	Yes / No	Relation
Glaucoma	Yes / No	Relation	Cataracts	Yes / No	Relation

PERSONAL EYE INFORMATION

Do you have any eye conditions or problems? Yes / No If yes, what kind? ______________

Have you had any eye operations? Yes / No Type ______________ Date ______________

Have you had an eye injury? Yes / No Type ______________ Date ______________

Do you have glaucoma?	Yes / No	Cataracts?	Yes / No	Dry eyes?	Yes / No
Macular degeneration?	Yes / No	Retinal detachment?	Yes / No	Blurred vision?	Yes / No
Do you wear glasses?	Yes / No	Contact lenses?	Yes / No	Type ______________	

Additional information ______________________

DOCTOR USE ONLY

Reviewed by ______________________ ☐ No changes Date ______________

Reviewed by ______________________ ☐ No changes Date ______________

Reviewed by ______________________ ☐ No changes Date ______________

11935 3/08

Dr. Delaney Offers a Visual Field Screening Test...

Screening tests serve an important clinical function by quickly surveying the visual field and flagging areas that are highly suspect. Abnormal test results warrant further investigation with threshold testing.

About Visual Fields ...

Eye care professionals appreciate the complexities involved in evaluating visual function and rely on an extensive and varied battery of diagnostic tests and instruments as part of the ocular examination. Without question, one of the most essential tools in the modem ophthalmic office is the computerized perimeter used to evaluate the visual field.

Although Dr. Delaney already tests for glaucoma and other ocular diseases and problems in a standard examination, a visual field t est has many additional benefits, which compliment Dr. Delaney's existing tests. The purpose of visual field testing is to provide information critical to:

- Diagnosing ocular diseases, especially glaucoma
- Evaluating neurological diseases
- Monitoring the progress of ocular diseases

Visual field testing can lead to early detection and treatment of disease. In the case of glaucoma, visual fields play a major role in identifying visual field defects and evaluating the effectiveness of the therapy used to control the disease process.

Although this test is optional and is not covered under your insurance plan, it is highly recommended.

SIGNATURE REQUIRED

I ACCEPT this test: ____

I DECLINE this test: ____

Date: ______________________________

Fee for visual field screening test: $19.00