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? (Choose all that apply)
   ☐ Routine Eye Exam ☐ Glasses ☐ Contacts ☐ Other:

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:

11. Are you pregnant or breastfeeding? (for dilation drops purposes) ☐Yes ☐No

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 using option 1 or 2.
Please let us know if you are: pregnant, breastfeeding your newborn, or allergic to eye drops.

Please PICK AN OPTION and sign/date under the option that best suits your needs!

Option 1: Retinal Imaging (HIGHLY RECOMMENDED)

If you select this option, we will take a photo of the back of your eyes.

- **Your vision will not be affected**
- **There is no waiting time**
- **The doctor will show you the photo and keep it on file from year to year**
- **Fee: $39** (not covered by insurance)

Name_____Signature_____ Date:_____

Option 2: Dilating Eye Drops

If you select this option, we will put dilating eye drops in your eyes.

- **Blurry vision and light sensitivity (2-6 hours typically)**
- **It takes 15-30 minutes for the drops to dilate eyes**
- **Fee: $0** (this service is included in your exam)

Name_____Signature_____ Date:_____

DECLINE BOTH OPTIONS (not recommended)

I understand that the doctor may not be able to detect cases in which the retina is diseased, physically compromised or harboring cancerous growths. As such, early detection and diagnosis of certain eye conditions, along with timely and effective treatment may not be possible. I accept all risks for by declining pupillary dilation and I understand that these conditions may result in permanent blindness or death.

Name_____Signature_____ Date:_____