Welcome to Glens Falls Eye Associates, a Division of Eyes NY. We appreciate your selection of our office for your complete medical eye care.

Enclosed are forms that will assist us in providing you with a thorough medical eye exam. Please complete the forms and bring them to your eye appointment.

**New patient appointments usually take 1-2 hours. As part of a new patient exam, your eyes will be dilated unless medically unable. It is recommended that you bring a driver. Your eyes will remain dilated for approximately 3-6 hours after your exam. During this time, your near vision is compromised, and you will experience light sensitivity.**
**We now offer a dilation reversal drop that is an out-of-pocket expense ( $20 )**

**LATE ARRIVAL/CANCELLATION/NO SHOW POLICY:**

Glens Falls Eye Associates is committed to providing exceptional care, unfortunately when one patient cancels without giving enough notice, they prevent another patient from being seen. Please review the following policies regarding late arrivals, cancelled appointments, and no show appointments:

If a patient is more than 15 minutes late for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary for the provider.

Office appointments which are cancelled with less than **24 hours** notice may be subject to a cancellation fee. To cancel a Monday appointment, please call the office by **12:00 PM on Friday.**

Patients who do not show up for their appointment without calling to cancel will be considered a **NO SHOW**. Patients who no-show appointments may be subject to a no show fee. Multiple no-shows may result in discharge from the practice.

If you wish to have the doctor discuss your treatment with a relative or friend, please have that person accompany you to your appointment.

The doctors and staff look forward to providing the highest quality eye care for you and we thank you for choosing Glens Falls Eye Associates.

| NAME: | DATE OF BIRTH: |
|---|---|
| **Local/Mail Order Pharmacy:** | |
| **Primary Care Physician:** | |
| **Reason for today's visit:** | |

**OCULAR HISTORY:**

When was your last eye exam?_____Where?_____

**Have you been diagnosed with any of the following eye diseases?:**

☐Blurry Vision ☐Cataracts ☐Macular Degeneration ☐Lazy Eye

☐Glaucoma ☐Dry Eye ☐Diabetic Retinopathy ☐Aphakia

☐Eye Trauma ☐Double Vision ☐Optic Neuritis ☐Keratoconus

☐Retinal Detachment/Tear ☐Flashes/Floaters

**Have you had any of the following Ocular Surgeries?**

☐blepharoplasty (YEAR: _____) ☐LASIK/PRK/RK (YEAR:_____) ☐Strabismus Surgery (YEAR:_____)

☐Cataract Surgery (YEAR:_____) ☐iLux Treatment (YEAR:_____) ☐Foreign Body Removal (YEAR:____)

☐Retinal Laser (YEAR:_____) ☐Punctal Plugs (Year:_____) ☐Corneal Transplant (YEAR:_____)

☐Vitrectomy (YEAR:_____) ☐SLT Laser (YEAR:_____) ☐Trabeculotomy/ectomy (Year:_____)

☐YAG laser (YEAR:_____)☐Peripheral Iridotomy (YEAR:___)☐Retinal Detachment Repair (YEAR:___)

Please list any other eye diagnoses, vision concerns or eye surgeries:_____

_____

**SOCIAL HISTORY:**

Do you smoke? ☐YES (Packs/Day_____) ☐NO Have you ever smoked? ☐YES ☐NO

Do you drink alcohol? ☐YES (How often_____) Do you use Substances? ☐YES ☐NO

Are you ?: ☐Employed(Full time☐ Part Time☐) ☐Retired ☐Disabled

Occupation:_____

**Do you have any disabilities? Please List:**_____

**Will you need wheelchair accommodation?**

☐ I am **UNABLE** to transfer to an exam chair ☐ I am **ABLE** to transfer to an exam chair

**MEDICAL HISTORY:**

Please mark next to any condition you currently have.

| | | | |
|---|---|---|---|
| ☐Hypertension | ☐Stroke/CVA | ☐Congestive Heart Failure | ☐Asthma |
| ☐Vascular Disease | ☐Diabetes (Type 1/Type 2, Year of Dx:_____) | | ☐Cancer |
| ☐Kidney Disease | ☐Cerebral Palsy | ☐Fibromyalgia | ☐Arthritis |
| ☐Muscular Dystrophy | ☐Osteoporosis | ☐GERD/ACID Reflux | ☐Gout |
| ☐Crohn's | ☐Ulcer | ☐Ankylosing Spondylitis | ☐COPD |
| ☐Sleep Apnea | ☐Emphysema | ☐Celiac Disease | ☐Eczema |
| ☐Rosacea | ☐Psoriasis | ☐Thyroid Disease | ☐Anemia |
| ☐HSV | ☐High Cholesterol | ☐Lupus | ☐Sjogren's |
| ☐HIV/AIDS | ☐Rheumatoid Arthritis | ☐Epilepsy | ☐Tumor |
| ☐Multiple Sclerosis | ☐Hearing Loss | ☐Sinusitis | ☐Migraines |
| ☐Depression | ☐Anxiety | ☐Bipolar Disorder | ☐ADHD |
| ☐Schizophrenia | ☐Heart Disease | ☐Pregnant | ☐Shingles |
| ☐Bell's Palsy | ☐Bleeding Tendency | ☐Developmental Disability | ☐Sarcoidosis |
| ☐Hepatitis | ☐Weight Loss | ☐Heart Attack | ☐MRSA |
| ☐Myesthenia Gravis | ☐Hepatitis | ☐Parkinson's | ☐Polymyalgia |

**Please list all surgeries you've had:**_____

_____

**FAMILY HISTORY**

Please list parents, grandparents, siblings, or children – living or deceased- with the following conditions:

Glaucoma:_____ Diabetes:_____

Lazy Eye:_____ Heart Disease: _____

Macular Degeneration:_____ High Blood Pressure:_____

Color Blindness:_____ Kidney Diesase:_____

Retinal Detachment:_____ Lupus: _____

Keratoconus:_____ Thyroid Disease:_____

Cataracts:_____ Cancer: _____

## MEDICATIONS

Please list all medications/supplements that you currently take and the dosage.

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## EYE DROPS

Please list ALL eyedrops that you currently use, including the number of times per day you use them

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## ALLERGIES

Please list your medication/environmental allergies

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