TWO TREES OPTOMETRY - KRISTOPHER R. SKROMME, OD
801 S. VICTORIA AV, SUITE 206 - VENTURA, CA. 93003

Patient Health History

Name: DOB: Date:

Briefly state any visual problems: _____

_____

Do you wear glasses? ☐NO ☐YES
Do you wear contacts? ☐NO ☐YES Are you interested in wearing contact lenses? ☐NO ☐YES

Patient Eye History
Indicate if any of these conditions apply to you:

☐Cataract ☐Macular Degeneration ☐Glaucoma ☐Retinal Detachment ☐Lazy Eye ☐Drooping Lid ☐Other_____

List any eye injuries and/or eye surgeries (**ie. Cataract surgery, LASIK, ect**.) please include dates and which eye:_____

_____

_____

Indicate if you are currently experiencing any of these symptoms:

☐Redness	☐Tearing/Watering	☐Double Vision	☐Foreign Body Sensation
☐Floaters	☐Dryness	☐Glare/Light Sensitivity	☐Eye pain/soreness
☐Flashes	☐Itching	☐Mucous Discharge	☐Loss of Vision

Further explanation, if needed:_____

_____

Patient Medical History
Indicate if any of these conditions apply to you:

☐Diabetes	☐Stroke	☐Allergies	☐Depression	☐Sinus Congestion	☐Vascular Disease
☐High Blood Pressure	☐Thyroid	☐Seizures	☐Bronchitis	☐Migraines	☐HIV/AIDS
☐Cholesterol	☐Cancer	☐Ashtma	☐Hepatitis	☐Anemia	☐Other _____

Further explanation, if needed:_____

_____

List any medications you take (including oral contraceptives, asprin, over the counter medications, and home remedies)

_____

_____

Do you have any allergies to medications ☐No ☐Yes If yes, explain:_____

Family History
Indicate any family history (blood relative) of the following conditions, and their relationship to you:

☐Cancer_____	☐ Cataract_____
☐Retinal Detachment_____	☐Diabetes_____
☐Glaucoma_____	☐High Blood Pressure_____
☐Macular Degeneration_____	☐Other_____

Patient Social History
Do you use tobacco products? ☐No ☐Yes If Yes, type:_____
Do you drink alcohol? ☐No ☐Yes If Yes, type:_____
Do you illegal drugs? ☐No ☐Yes If Yes, type:_____
Is there anything private you would like to speak with the doctor about? ☐No ☐Yes
Women Are you pregnant? ☐No ☐Yes Are you breastfeeding? ☐No ☐Yes

Please sign below to acknowledge that this form is correct.

Signature: _____

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TREATMENT CONSENT FORM

RETINAL EXAM

Dr. Skromme recommends that you have your eyes dilated and perform a retinal photo screening. The following groups are in greatest need:

- Diabetics
- Age 50 or older
- Nearsighted (myopic) people with a strong prescription
- Anyone with a history (self or family) of glaucoma, macular degeneration, high blood pressure, and migraine headaches
- Anyone experiencing flashes of light or floaters

Dilation will increase your light sensitivity and decrease your close vision for 2-3 hours. Since everyone is different, the effects of the drops could last as long as 5 hours. Dilation is at no cost to you.

Retinal photo screenings is a more advanced way of checking the health of your eyes. It will establish a base line photo which can be used to compare future subsequent photos. Retinal photos are $29.00 and are not covered by insurance.

Dilation drops are not recommended for women who are pregnant or nursing.

Please indicate below if you would like to have your eyes dilated and/or perform the retinal image screening.

Dilation:	Retinal Photos:
_____YES	_____YES
_____NO	_____NO

CONTACT LENS EVALUATION & FITTING

This portion is for someone interested in wearing, or currently wearing, contact lenses. A contact lens is a medical device and requires a different evaluation than your eyeglasses. A contact lens evaluation must be done every year with the doctor to order contact lenses. Contact lens fees may vary from $65-$135. Ask us if your insurance provides any discounts towards these fees.

_____Yes, I would like a contact lens fitting
_____No, I am not interested in contact lenses.

Patient / Guardian Signature_____ Date:_____