Eye Wellness Digital Retinal Screening

At All EyeCare Optometry, we are continuously investing in new technologies to detect eye diseases earlier. There are over 200 different conditions that can be detected within the eye, and our mission is to be able to diagnose and treat those conditions, such as glaucoma and macular degeneration, before they can threaten your vision or health.

Our office currently features two technologies:

1) Optomap scan (wide view): (Available in office since 2013)

- Wide angle retinal scan
- Images 85% of retina
- Creates permanent baseline
- Views comparable to dilation

Doctor Recommendation:

1) One baseline for age 8 and above

Indications for annual repeated scans:

1) If dilation is not being performed
2) Medical history of any systemic disease, especially diabetes, high blood pressure, and high cholesterol
3) Family history of glaucoma or macular degeneration

2) Optical coherence tomography (OCT; deep view): (New to office in 2018)

- Cross sectional scan
- Detect diseases on a microscopic level
- Instant, direct imaging of tissue morphology
- No ionizing radiation
- Microscopic resolution of the retinal tissue better than 0.01mm in thickness

Doctor Recommendation:

1) One baseline image for age 18 and above

Indications for annual repeated scans:

1) Age 50 and above
2) Patients with diabetes and/or high blood pressure
3) Patients with autoimmune diseases
4) Concerns for glaucoma
5) Family history of glaucoma or macular degeneration

In our mission to ensure that you maintain optimal eye health, we have brought in technology to help detect glaucoma and retinal diseases earlier. Vision insurances **will not** cover these additional tests.

If you decide to defer taking Optomap or the OCT images, we recommend at minimum annual dilated examinations.

__________ I AGREE TO THE RECOMMENDED **OPTOMAP AND OCT** SCANS ($50).

__________ I **DECLINE** THE SCREENING OPTIONS AND PREFER TO BE **DILATED.**
I understand my vision will be blurry when reading, and I will be light sensitive for 3-4 hours.

Patient name (please print): ______________________________

Signature: ______________________________ Date: __________

12/2018

CONTACT LENS CARE AGREEMENT:

Contact lenses are FDA class I medical devices that have the potential for serious complications if not used and fitted properly. For that reason, the standard of care and the requirements of the California State Board of Optometry require an annual examination for renewal of a contact lens prescription. In addition to general eye health assessment, the doctor will assess issues related to contacts such as abnormal blood vessel growth, corneal damage, chronic inflammation, hygiene, discomfort, and poor surface compatibility, in addition to any vision changes. The ***estimated fee*** for these services range ***between $75.00 and $125.00***. These fees will cover any contact lens related follow ups for a 30 day period. If you cannot complete the fitting procedure in the allotted time due to missed follow up appointments, there will be an additional $25.00 charge per visit beyond the global time period. Additional fees for ***training for insertion and removal*** of contact lenses range between ***$40.00 and $60.00*** and apply to all new wearers. **Your insurance copay:** ________

By signing, I acknowledge that I understand the policies regarding the contact lens health evaluation and agree to the associated fees. I understand that these fees are an estimate and are subject to changes based on the doctor's final assessment. I also understand that improper usage of contact lenses as prescribed can lead to vision loss and permanent eye damage. I understand that if an infection is present, I will need to be treated under my medical insurance prior to being refit with contact lenses.

Signature:______________________________ **Date:**____________________

CONTACT LENS QUESTIONNAIRE:

Specifications: Brand of Contacts:______________________ Solution Name:________________

Vision:

Can you see distance and near comfortably with your contact lenses? **Yes** **No**

Life Style:

How many days a week do you wear your contact lenses? ______________days / week

How many hours a day do you wear your contact lenses? ______________hours / day

If you store your lenses in solution, do you discard your solution every morning? **Yes** **No**

Do you sleep overnight in your contact lenses? **Yes** **No**

If you sleep in your contacts, for how many nights in a row? ______________nights

Do you swim in your contact lenses? **Yes** **No**

Do you shower in your contact lenses? **Yes** **No**

Comfort:

Do you experience dryness with your contact lenses? **Yes** **No**

Do you have difficulty with seasonal allergies? **Yes** **No**

Contact Lens Health History

Have you had a contact lens related eye infection or complication? **Yes** **No**

If yes, please explain: ______________________

Have your eyes become contact lens intolerant over the years? **Yes** **No**

Hygiene:

Do you have a backup pair of glasses? **Yes** **No**

Do you rub your contact lenses with solution when cleaning? **Yes** **No**

How often do you change your contact lens case? ______________________

How often do you change your contact lenses? ______________________

Please rank from most important to least important so that the doctor can prescribe to enhance your contact lens experience

(1 – Most important, 4- Least important): ____Convenience ____Comfort ____Clarity ____Cost

How can we improve your experience with your contact lenses? ______________________________

All Eyecare Optometry SPEED II Questionnaire for Dry Eye Disease

Name: ______________________ **Gender:** ______________ **Date:** ______________

Dry eye disease is one of the most frequent reasons patients visit eye doctors. We are concerned that you may be suffering from this condition as well. Please complete the questions below so we can ensure your eye health and comfort. **Select only one answer per question.**

1. Report the **FREQUENCY** of your symptoms using the rating list below:

0 = never   **1** = sometimes   **2** = often   **3** = constant/always

Symptoms	**0**	**1**	**2**	**3**
Dryness, grittiness, or scratchiness				
Soreness or irritation				
Burning or watering				
Eye fatigue				

2. Report the **SEVERITY** of your symptoms using the rating list below:

0 = no problems
1 = tolerable - not perfect, but not uncomfortable
2 = uncomfortable - irritating, but does not interfere with my day
3 = bothersome - irritating and interferes with my day
4 = intolerable - unable to perform my daily tasks

Symptoms	**0**	**1**	**2**	**3**	**4**
Dryness, grittiness, or scratchiness					
Soreness or irritation					
Burning or watering					
Eye fatigue					

3. Please check if you have experienced the previous symptoms (select as many as needed):

❒ Today   ❒ In the last 3 days   ❒ In the past 3 months   ❒ Not applicable

4. Do you use eye drops or an ointment?

❒ No   ❒ Yes   How often? ____________ drop(s) per day / week / month

5. Did you use eye drops today?

❒ No   ❒ Yes

6. What is the name of the drops you use? ______________________________

For office use only:
Total SPEED score (frequency + severity) = ____ / 28
❒ No dry eye (0-5)   ❒ Mild (5-6)   ❒ Moderate (6-10)   ❒ Severe (≥ 10)