DILATION CONSENT

Dilation is important for the inspection of the periphery of the eye for the presence of tumors, retinal detachments and other conditions such as floaters, flashes or spots appearing suddenly in the vision. The need to record the use of dilating agents has become a standard on determining the thoroughness of the examination. NOTE: Due to the widening of the pupil, dilation will affect the comfort of many patients when reading and create light sensitivity, usually lasting approximately 4 - 6 hours, but may last overnight.

DATE _____

I ***ACCEPT*** Dilation _____
Signature

I ***DECLINE*** Dilation _____
Signature

I understand that I am responsible for all charges my insurance does not pay.

_____ **Signature**

FAMILY MEDICAL HISTORY

DO YOU OR ANY FAMILY MEMBER HAVE OR EVER HAD: ***S= SELF F=FAMILY***

___ **Diabetes**
___ **Glaucoma**
___ Blindness
___ Double Vision
___ Flashes of Light
___ Floaters
___ Light Sensitivity
___ Macular Degeneration
___ Fainting/Dizziness
___ Allergies
___ Hearing Problems
___ Vision Training/Eye Exercises
___ **Women:** Currently Pregnant

___ **Cataracts**
___ **Thyroid**
___ Color Blindness
___ Lasik/PRK Surgery
___ Near Vision Blurred
___ Distance Vision Blurred
___ Eye Surgery
___ Retinal Diseases
___ Sudden Vision Loss
___ Head/Eye Injury

___ **Heart/Vascular Disorders**
___ **High/Low Blood Pressure**
___ High/Low Blood Sugar
___ Eye Turn/Lazy Eye Problems

___ Dry Eyes
___ Redness, Itching, Burning Eyes

___ History of Migraines
___ Sleep Problems
___ Fainting Spells
___ Headaches

List All Medications You Are Currently Taking:

_____
_____
_____

Are You Allergic to Any Medications:

_____
_____
_____