# Dr. Mark W. Mathews & Dr. Vijay Shenai

Chart #: _____ **Date:** _____

Patient Name: _____

Circle One: Mr. Mrs. Miss Ms. Dr. Rabbi Rev.

Cell Phone # _____ **Texting Okay?** ☐Yes ☐No

Email: _____

**Dilation:** Our office strongly encourages dilation for all new and returning patients as part of a comprehensive eye exam. Side effects include, but are not limited to, increased light sensitivity and blurred vision lasting 2-4 hours. This procedure allows the doctor to more thoroughly examine internal eye health. If you decline this procedure, please understand that the doctor will be limited in his/her ability to diagnose and treat certain ocular conditions.

Initial and Check one:
☐YES, I am prepared to be dilated today
☐NO, I decline dilation today. I understand the importance of dilation and the risks

HIV/AIDS Positive: ☐Yes ☐No **Are you pregnant?** ☐Yes ☐No

Prior Blood Transfusions: ☐Yes ☐No **Are you nursing?** ☐Yes ☐No

Do you drive? ☐Yes ☐No

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐White ☐Black/African American ☐Asian
☐Hispanic ☐Native Hawaiian/Other Pacific Islander

Ethnicity: ☐NOT Hispanic/Latino ☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander

Tobacco Use: ☐Never Smoked ☐Current smokeless tobacco user
☐Former Smoker (# years since quit:___)
☐Current everyday smoker (# packs per day: ____)

Alcohol Use: ☐None ☐1-2 Drinks Daily ☐ Alcohol Dependent
☐Social Use Only ☐Above Average Use