VISION SOURCE
Family Vision Care
Contact Lens Specialists
JAMES L. GRECO, JR O.D.
OPTOMETRIC PHYSCIAN
4710 N. HABANA AVE SUITE 204
TAMPA, FLORIDA 33614-7146

RADIO FREQUENCY MEDICAL HISTORY FORM

Last Name: _____ First Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Telephone Home: _____ Work: _____ Cell: _____
Date of Birth: _____ Sex: Female ____ Male: ____
Family Doctor: _____ Phone: _____
Pharmacy: _____ Phone: _____
Emergency Contact: _____ Phone: _____

Which body area(s) or condition would you like treated? _____
_____
_____

Please answer all of the following questions:

1. __Yes ___No Do you have ANY current or chronic medical illnesses?
   Disclose any history of heart urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.
   Please list: _____
2. __Yes ___No Do you have ANY current or chronic skin conditions?
   Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danios syndrome, scleroderma, skin cancer, or any other skin condition.
   Please list: _____
3. __Yes ___No Are you currently under a doctor's care?
   If yes, for what reason?
   _____
4. __Yes ___No Do you take/use ANY medications (prescription and nonprescription), aspirin, vitamins, herbal or natural supplements, on a regular or daily basis?
   Please list: _____
5. __Yes ___No Have you ever had Gold Therapy Treatment (chrysotherapy, aurotherapy, Gold sodium thiomalate GST)
6. __Yes ___No Are there any tropical products (both medical and non-medical) that you use on your skin on a regular or daily basis?
   Please list: _____
7. __Yes ___No Do you have ANY allergies to medications, food, latex, gold or other substances?
   Please list: _____
8. (For women) __Yes ___No Are you or could you be pregnant?
9. (For women) __Yes ___No Are your pap smears gynecologic physicals normal?
10. __Yes ___No Do you have a history of herpes I or II in the area to be treated?
11. __Yes ___No Do you have a history of keloid scarring or hyperthropic scar formation?
12. __Yes ___No Do you have any open sores or lesions?
13. __Yes ___No Do you have any history of radiation therapy in the area to be treated?
14. __Yes ___No In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood-thinning medications?
    Please list product name and date last used:
    _____

Vision Source

Family Vision Care

Contact Lens Specialists

JAMES L. GRECO, JR O.D.
OPTOMETRIC PHYSCIAN

4710 N. HABANA AVE SUITE 204
TAMPA, FLORIDA 33614-7146

15. __Yes ___No In the last three (3) months, have you used any of the following products? Gycolic acid or other alphahydroxy or betahydroxy acid products, chemical peels, exfoliating or resurfacing products or treatments? Please list product name and date last used:

_____

16. __Yes ___No Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers, including, but not limited to: collagen, autologous fat, Restylane®, etc.?
If yes, please list locations on or in the body and dates:

_____

17. __Yes ___No Do you have or have you ever had any Botulinum, such as Botox® or Dysport®?
If yes, please list locations on or in the body and dates:

_____

18. __Yes ___No Have you taken Accutane® (or products containing isotretinoin) in the last 6 – 12 months?

19. __Yes ___No Have you taken Tretinoin (like Retin-A®, Renova®) in the last 14 days?

20. __Yes ___No Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last two weeks?

21. __Yes ___No Do you have a pacemaker, implantable Cardia Defibrillators (ICD) or Cardiac Resynchronization Therapy (CRT) devices?

22. __Yes ___No Do you have any metal implants or embedded electronic devices?

23. __Yes ___No Do you have nerve insensitivity to heat?

24. ___Yes ___No Do you have a history of bleeding coagulopathies or are you currently taking antiplatelet, thrombolytics, anti-inflammatories or anticoagulants?

Signature: _____

Date: _____

VISION SOURCE
Family Vision Care
Contact Lens Specialists
JAMES L GRECO, JR O.D.
OPTOMETRIC PHYSCIAN
4710 N. HABANA AVE SUITE 204
TAMPA, FLORIDA 33614-7146

Client Pre-Treatment Instructions for TempSure™ Wrinkle Treatment

- Remove all makeup, including eye makeup, lotions or sun block and wash facial area prior to treatment. Any preparations left on the skin will act as impedance to the energy and will diminish the effects.

- Neurotoxins or fillers should be given post-treatment or a minimum of two weeks prior to the TempSure Treatment.

- For five to seven days prior to treatment, at the physician's discretion, avoid therapies that may cause erythema (redness) or irritation such as Retin-A or products containing Isotretinoin, glycolic and or salicylic acid.

- The treatment area must be free of any open lesions or infections

- For an optimum treatment, hydrate by drinking plenty of water or hydrating fluids several days in advance. Avoid alcohol if possible.

VISION SOURCE
Family Vision Care
Contact Lens Specialists
[redacted] GRECO, JR O.D.
OPTOMETRIC PHYSCIAN
4710 N. HABANA AVE SUITE 204
TAMPA, FLORIDA 33614-7146

Client Post-Treatment Instructions for TempSure™ Wrinkle Treatment

Typically, clients may return to their normal activities after receiving a TempSure treatment. Please follow the medical advice of the physician regarding the care of your skin.

- Wash skin with tepid water and a gentle cleanser.

- If the skin is slightly pink or red in areas following the treatment, avoid hot water when washing or showering until any erythema (redness) has subsided.

- Makeup, preferably mineral-based, may be applied immediately post treatment.

- Soothing creams or moisturizers may be used.

- Use a sun block with an SPF of 30 or greater if going out into the sun to help prevent future sun damage. This treatment does not cause photosensitivity.

The practitioner will describe the nature and timing of skin improvement that may be noticed over time. If there are any further questions or concerns, contact the physician's office.

DR. JAMES L. GRECO, JR O.D. | Optometric Physician | 4710 N. HABANA AVE SUITE 204 | TAMPA, FL 33614-7146

Patient ID: _____ Date: _____

Please complete this questionnaire. It will help to grade the severity of your Dry Eye symptoms.

Have you experienced any of the following symptoms?	0 None of the time	1 Some of the time	2 Half of the time	3 Most of the time	4 All of the time	Scoring 0-4
1. Sensitivity to light, during the last week						
2. Gritty or scratchy sensation, during the last week						
3. Burning or stinging, during the last week						
4. Blurred/unclear vision, during the last week						
5. Vision that fluctuates with blinking, during the last week						
6. Vision that improves with artificial tears, during the last week						
7. Tearing/watering, during the last week						
8. Pain/burning during the night or upon awakening in the morning, during the last week						
Have you experienced eye irritation while performing any of these activities?						
9. Reading or driving a car for long periods, during the last week						
10. Watching TV/working on a computer for an extended period, during the last week						
Have your eyes felt uncomfortable in any of the following situations?						
11. During wind/air draft exposure, during the last week						
12. In places with low humidity (heated/cooled places, i.e. planes), during the last week						
					TOTAL SCORE: Add Score from Questions 1 - 12	

How much do your eyes bother you? Please check box from 1 – 10

1 Not at all — 2 — 3 — 4 — 5 Moderately — 6 — 7 — 8 — 9 — 10 Extremely & Constantly

Please answer the following questions:

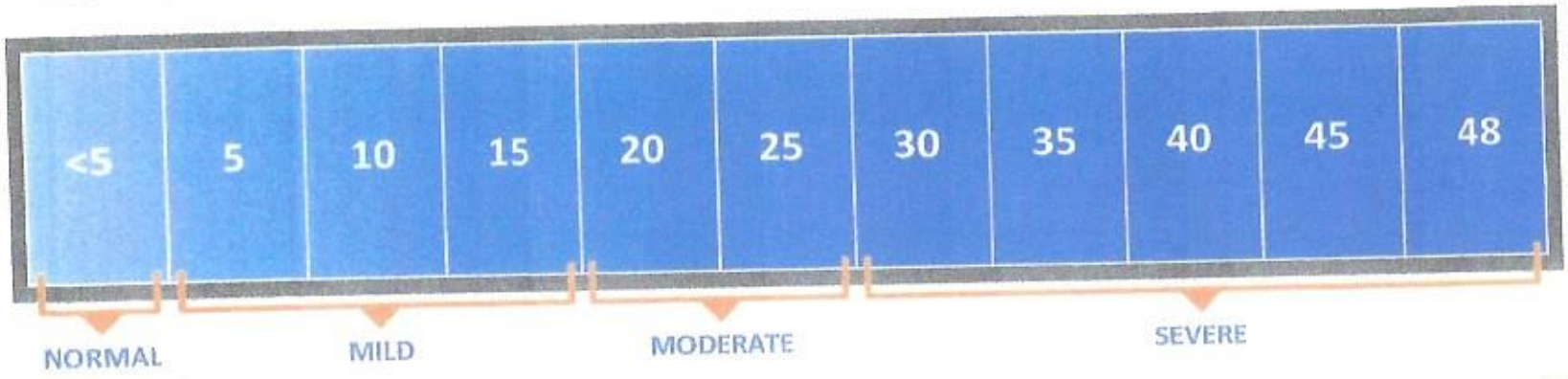
A. What brand of artificial tears are you using?

B. How often do you use artificial tears? Times per day? Days per week?

C. Are your symptoms better, worse or the same as your last visit? ○ Better ○ Worse ○ Same

DR. JAMES L. GRECO, JR O.D. | Optometric Physician | 4710 N. HABANA AVE SUITE 204 | TAMPA, FL 33614-7146

Total all points from questions 1–12 and grade your patients' Dry Eye severity using the gradient chart below.



Comments:

Jackson WB. Management of dysfunctional tear syndrome. *Can J Ophthalmol* 2009;44(4):385–394.

VISION SOURCE

Family Vision Care

Contact Lens Specialists

JAMES L. GRECO, JR O.D.
OPTOMETRIC PHYSCIAN

4710 N. HABANA AVE SUITE 204
TAMPA, FLORIDA 33614-7146

Treatments may include, but are not limited to:

- Lid margin hygiene to encourage better oil gland production
- Discussion of supplements that may be beneficial
- Possible prescription eye drop medication
- TempSure Envi procedures to revitalize the oil glands along the lid margins
- ICON IPL (intense pulse light therapy) to reduce redness and vessel inflammation around the eyes and Demodex eradication
- Amniotic membrane technology
- Scleral lenses
- Autologous serum eye drops
- or, a combination of these strategies

Over my course of my practicing career as an Optometrist I grew increasingly frustrated. Legacy treatments only treated the symptoms but were incapable of addressing the root cause. Now we have the solution!

At *Dr. James L. Greco, Jr O.D.* we are a results-oriented clinic that is determined to exceed your expectations and make the greatest positive impact we possibly can on your eye health. I can now confidently say that we are able to achieve our standard for those of you who suffer from dry eye.

If you suffer from dry eye or believe that you may; please contact our office at **813.879.0324** or by email at: **cynosure@drjamesgreco.com** to book your assessment.

Sincerely,

Dr. James L. Greco, Jr O.D.
813.879.0324