Doctors For Visual Freedom

Patient Information

Please Type, or Print Clearly **Date** _____

_____ _____ _____ ☐ **Male** ☐ **Female**

Last Name **First Name** **MI** **Date of Birth** **Age**

_____ _____ _____ _____

Current Street Address **City** **State** **Zip Code**

Home Telephone (_____) _____ **Email** _____

Work Telephone (_____) _____ **Cell** (_____)_____

Employer _____ **Occupation** _____

Employers Address _____

Emergency Contact _____ **Telephone #**_____**Relationship** _____

Social Security Number (SSN) _____ ☐ **Married** ☐ **Single** ☐ **Widow** ☐ **Other**

HOW DID YOU HEAR ABOUT US / WHO REFERRED YOU?

☐ Physician, ☐ Optometrist, ☐ Friend / Relative_____, ☐ Yellow Pages, ☐ Facebook, ☐ Website, ☐ Better Doctor
☐ Google, ☐ Yahoo, ☐ TopDoc, ☐ ZocDoc, ☐ Angie's list, ☐ Manta, ☐ Other_____

Your Physician: Name _____ MD/DO Address_____
City_____ State _____ Zip _____ Phone _____

Your Optometrist: Name _____MD/DO Address_____
City_____ State _____ Zip _____ Phone _____

What medications are you currently taking? _____
_____
Eye medications? _____
Allergies? _____
How old are your glasses? _____
How often does your prescription change? _____
Do you wear contact lenses? ☐ Yes ☐ No
If yes, What type? ☐ Soft daily ☐ Soft Toric ☐ Soft extended ☐ Gas Permeable
Do you sleep in your contact lenses? ☐ Yes ☐ No
If you wear reading glasses, have you tried Monovision Contact Lenses? ☐ Yes ☐ No
How long have you worn contact lenses? _____
Please list any history of eye problems or eye surgery in yourself or a member of your immediate family?
_____
_____
What is the reason for your visit? _____
_____

How concerned are you with the appearance of any fine lines or wrinkles on your face?
☐ Not Concerned ☐ Somewhat Concerned ☐ Very Concerned

Medical History:
Present Review of Systems (Check if any apply.)

- ☐ High blood pressure (___yrs)
- ☐ Heart disease
- ☐ Heart Pain
- ☐ Diabetes (_____yrs)
- ☐ Rheumatoid Arthritis
- ☐ Weight Loss/Gain
- ☐ Breathing problems
- ☐ Skin problems
- ☐ Headaches
- ☐ Cancer (type _____)
- ☐ Depression
- ☐ Neurological Systems
- ☐ Psychiatric
- ☐ Allergic/Immunologic
- ☐ Sinus congestion
- ☐ Dry throat/mouth
- ☐ Chronic cough
- ☐ Chronic Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ HIV positive
- ☐ Gastrointestinal (stomach)
- ☐ Hay fever
- ☐ Ear, Nose, Mouth, Throat
- ☐ Stroke (when ____)
- ☐ Poor Circulation
- ☐ Bones, joints, muscles
- ☐ Constitutional (fever)
- ☐ Joint Pain
- ☐ Endocrine
- ☐ Kidney Problems
- ☐ Migraines
- ☐ Prostate disease
- ☐ Do you take Flomax?
- ☐ Drooping Eyelids
- ☐ Refractive Surgery
- ☐ Keratoconus
- ☐ Eye Injury
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Retinal Problems
- ☐ Crusty eyelashes
- ☐ Glaucoma
- ☐ Crossed Eyes
- ☐ Vision Loss
- ☐ ***Are your immunizations up to date?***

Other _____
_____

Past Medical History:
List all surgeries & hospitalizations you have had in the past
_____
_____

Social History:
Do you use tobacco products? ☐ Yes ☐ No If so: _____packs per day
Do you drink alcoholic beverages ☐ Yes ☐ No If so: _____drinks per week

Family History: (list any medical problems in your family)
☐ Glaucoma ☐ diabetes ☐ high blood pressure ☐ crossed eyes ☐ lazy eye ☐ keratoconus ☐ retinal problems
☐ cancer ☐ arthritis ☐ gout ☐ heart disease ☐ kidney disease ☐ lupus ☐ stroke ☐ thyroid ☐ lung problems
Other _____
_____

Is there anything else we should know about you and your general health?
_____
_____

Patient Signature _____ Date _____

Dry Eye
Symptoms Checklist

Name (Please print):_____

Please check all of the symptoms you are currently experiencing.

- ☐ Burning eyes
- ☐ Sandy or gritty feeling
- ☐ Itching
- ☐ Dryness of the eyes
- ☐ Watering eyes
- ☐ Sensation of foreign matter in eyes
- ☐ "Tired eyes"
- ☐ Constant or occasional tearing
- ☐ Lid infection
- ☐ Discomfort with bright lights
- ☐ Redness
- ☐ Light sensitivity
- ☐ Eye pain or soreness
- ☐ Stringy mucus in or around the eyes
- ☐ Fluctuating vision

Related Conditions:

- ☐ Allergies or hay fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic cough
- ☐ Dry throat or mouth
- ☐ Sneezing
- ☐ Headaches
- ☐ Middle ear congestion
- ☐ Joint/arthritis pain
- ☐ Nasal or sinus congestion
- ☐ Post-nasal drip
- ☐ Runny nose

Do you use any type of lubricating eye drops or artificial tears? _____

Do you have seasonal allergies? _____

Do you use eye drops for the treatment of glaucoma? _____

Are your eyes sensitive to:
(Please circle all choices that apply.)

- ☐ air conditioning
- ☐ dust
- ☐ pollen
- ☐ tobacco smoke
- ☐ wind
- ☐ contact lens wear
- ☐ heaters
- ☐ smog
- ☐ video display terminals

If you wear contact lenses or have worn contact lenses in the past, please answer the following questions:

Yes	No	
☐	☐	Do you currently wear contact lenses?
		If so, how long have you worn them? _____ years
☐	☐	Are they comfortable throughout the day?
☐	☐	Are your eyes sensitive to contact lens solution?
☐	☐	Have you worn contact lenses before, and then quit for some reason?

If so, what caused you to quit wearing them?_____

Signature:_____ Date:_____

Doctors For Visual Freedom

TO OUR PATIENTS: We are required by Federal Law entitled "Health Insurance Portability and Accountability Act" to present you with the following form for your review and signature:

With patient consent, Doctors for Visual Freedom may use and disclose protected health information to carry out treatment, payment, and healthcare operations only. This includes, but is not limited to:

- appointment reminder calls to your home
- mailing information to your home regarding our practice
- calling and faxing prescription authorization to your pharmacist

Certain practices are NOT approved uses for your protected health information and will not ever be performed. This includes:

- Selling your information to any third parties for marketing purposes
- releasing your information for any purposes without your signed consent

To help us protect your health information, we will maintain a copy of your driver's license or state identification card with your signature on file. If you wish, you do have the right to review the Notice of Privacy Practices prior to signing this consent. You will likely be seeing this notice, or ones similar to it, at other health care facilities. Doctors for Visual Freedom reserves the right to revise its Notice of Privacy Practices at any time, within the parameters of HIPAA. A revised Notice of Privacy Practices may be obtained by sending a written request to the Doctors for Visual Freedom Privacy Officer.

You have the right to review your medical records and make amendments to those records. Records may be obtained by sending a written request to the Doctors for Visual Freedom.

You have the right to submit a written request that Doctors for Visual Freedom restricts how it uses or discloses your protected health information.

You may revoke this consent in writing except to the extent that the practice has already made disclosures with this prior consent.

Please check:

YES ☐ **NO** ☐ Doctors for Visual Freedom may call my home, or another designated number and leave a message, recorded or with a person, regarding items that assist the practice in carrying out treatment, payment, and operations.

YES ☐ **NO** ☐ Doctors for Visual Freedom may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

YES ☐ **NO** ☐ Doctors for Visual Freedom may email to my home or other designated location any items that assist the practice in carrying out treatment, payment, and operations.

YES ☐ **NO** ☐ Doctors for Visual Freedom may text message my cellular phone with any information that assists the practice in carrying out treatment, payment, and operations.

Patient Name _____Date of Birth _____

Signature_____Date_____