Optical *Expressions*

Date_____/_____/_____

Patient History Questionnaire 1/2

DEMOGRAPHICS--mark any updates since we last saw you: **Please Fill in Name even if no change**			**○ NO CHANGE**
Last name:	**First name:**		**MI:**
Address:	**City/St:**		**Zip:**
DOB: **SS #:**	**Email:**		
○ Cell same as home **Cell:**	**Work:**		**Home:**
Would you like to have online access to your health records? ○ Yes ○ No			
Occupation:	**Employer:**	**○ Full time**	**○ Part time**
Emergency Contact:	**Contact #:**		
Race: ○ Asian ○ African American/Black ○ Pacific Islander ○ Caucaian/White ○ Unknown/Other:			
Ethnicities: ○ Hispanic/Latino ○ Not Hispanic/Latino ○ Other:		○ Decline Race & Ethnicities	

INSURANCE INFORMATION-mark any updates since we last saw you:		**○ NO CHANGE**
Main Insured:	**Main SS#:**	**Main DOB:**
Medical:	**Medical ID#:**	
Vision Insurance:	**○Advantica ○Always Vision ○Davis ○Health Scope ○Envolve ○Eyemed ○NVA ○Spectra ○Superior ○UHC ○VSP ○VBA ○Eyequest ○Humana** **Other:_____**	
Vision ID#:	**○ Primary Member on Vision and Medical**	

FAMILY HEALTH HISTORY-mark any updates since we last saw you:									**○ NO CHANGE**
High Blood Pressure	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter
Macular Degeneration	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter
Retinal Detachment	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter
Diabetes/Type:___	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter
Cataracts	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter
Cancer	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter
Hypo/HyperThyro	Yes	No	***Relationship:***	Father	Mother	Bro.	Sis.	Son	Daughter

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PERSONAL MEDICAL HISTORY:								
Height:			**Weight:**			**What is your general Health?**		
Have you had any NEW issues since we last saw you: (Circle Yes/No) ○ **NO CHANGE**								
Eyes	Yes	No	**Gastrointestinal**	Yes	No	**Integumentary (Skin)**	Yes	No
Ear/Nose/Throat	Yes	No	**Urinary**	Yes	No	**Cardiovascular**	Yes	No
Endocrine (Glands)	Yes	No	**Respiratory**	Yes	No	**Blood/Lymph**	Yes	No
High Blood Pressure	Yes	No	**Allergies**	Yes	No	**Nervous System**	Yes	No
Headaches	Yes	No	**Muscles/Bones**	Yes	No	**Mental**	Yes	No
Please explain:								
Diabetes	Yes	No	**Type:**			**Date of Diagnosis:**		
Current Medications?								
Allergic to:			**Reaction:**			**Latex Allergy**	Yes	No
Operations?	Yes	No	**Type?**			**Date:**		
Family Dr. :			**Phone:**			**Fax:**		
Date of Last visit:			**Date of last tetanus shot:**					
NEW CONDITIONS OR PROBLEMS *since we last saw you:* ○ **NO CHANGE**								
Blurred Vision	Yes	No	**Do you wear reading glasses?**	Yes	No	**Contact Brand:**		
	Yes	No	**Do you wear glasses?**	Yes	No	**Type:**		
Alcohol	Yes	No	**Frequency:**			**Power Reye:**		
Tobacco	Yes	No	**Frequency:**			**Power Leye:**		
Illegal Drugs	Yes	No	**Frequency:**			**B.C./DIA:**		
Have you traveled outside the U.S within the past 60 days?	Yes	No	**Have you traveled outside the State of Missouri within the past 60 days?**	Yes	No	**Have you traveled to Chicago, Detroit, Nashville, New York, New Jersey, Atlanta or Florida within the past 60 days?**	Yes	No
Have you had any flu symptoms?	Yes	No	**Do you have any cough symptoms?**	Yes	No	**Have you or anyone you have had contact with been tested for Covid-19?**	Yes	No

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Print Name: _____ DATE:____/_____/_____ **SPEED**

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

Report the type of ***SYMPTOMS*** you experience and when they occur:	At Visit		Within last 72 hrs		Within last 3 months	
Symptoms	Yes	No	Yes	No	Yes	No
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

Report the ***FREQUENCY*** of your Symptoms using the rating listed below:

0 = Never
1 = Sometimes
2 = Often
3 = Constant
4 = Intolerable

Symptoms	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

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

0 = No Problems
1 = Tolerable-not perfect, but comfortable
2 = Uncomfortable-Irritating, but doesn't interfere with day
3 = Bothersome-Irritating and interferes with day
4 = Intolerable-unable to perform daily tasks

Symptoms	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

Do you use eye drops for lubrication? ▢ No ▢ Yes, Type:_____

And how often? _____

Office use:Total SPEED Score: (Frequency + Severity=_____ /28)

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OPTOMAP

Optical Expressions is proud to provide the latest in retinal imaging. ***The OPTOMAP is obtained annually for every patient.*** We now provide imaging of the retina on all patients with a new scanning digital system called Optomap. Prior to Optomap the way to thoroughly examine the retina was dilaton. *The optomap only takes a few seconds to perform and is done without dilation. It provides a permanent, digital image of the inner layers of your eye, which your doctor will be able to review with you in the exam room today.* Many eye conditions such as glaucoma, macular degeneration, diabetic retinopathy, melanoma or other tumors are painless and have no symptoms in their early stages. This invaluable tool will help us more easily detect and monitor many disease processes of the eyes. **EARLY DETECTION OF EYE DISEASE IS CRUCIAL!**

The test is often covered by insurance, but if not it will cost $19.

SIGNATURE ON FILE

- ❑ I authorize the use of this form on all of my insurance submissions.
- ❑ I authorize the release of information to all of my insurance carriers.
- ❑ I understand that I am responsible for my bill.
- ❑ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
- ❑ I authorize payment directly to my doctor.
- ❑ I permit a copy of this authorization to be used in place of the original.
- ❑ I authorize this document as my HIPPA form, I understand I can request a detailed HIPPA at any point from Optical Expressions. You may also view the Hippa compliance on our website under forms.

Date _____ Print Name/Guardian _____

Signature/Guardian _____

Patient Name (if not self): _____

MACULAR DEGENERATION RISK FACTORS

About *YOURSELF*	Yes	About your FAMILY	Yes
Age: 30 & over			
Sensitive to light			
Female			
Excessive exposure to the sun		Macular Degeneration	
Light eyes, light skin		Glaucoma	
Inadequate intake of green, leafy veg		Cataract	
Smoker Yes-if you quit/or social/2nd hand		High Blood Pressure	
Glaucoma		Diabetes	
High Blood Pressure		Heart Disease	
Diabetes			
Heart Disease			
Cataract			
PERSONAL TOTAL		**+ FAMILY TOTAL**	

QUANTIFEYE

To our Patients,
We continuously strive to provide our patients the very best in eye care services. This device allows us to assess your risk of developing an eye disease called Macular Degeneration. This disease is a leading cause of blindness in adults and there is no adequate treatment; however, it may be managed if caught early. We can now take measures to reduce your risk of developing this disease.
The test is a light response test that only takes a few minutes. We strongly recommend that you take this test so we can assess your risk for Macular Degeneration and develop a base-line measurement that allows us to track any changes that might occur in the future. Since this is a new test, it is not covered by your insurance; however the cost to you is a minimal charge of $20.00

Optical Expressions,
Thomas Cullinane, OD, Judie Miles, OD, Julie Emming, OD, Jeffery Weaver, OD

I understand my risk factors for Macular Degeneration and choose to:
◯ Accept Test ◯ Decline Test
IInitial:_____

For Office use only:Personal+Family= _____ ◯ High ◯ Medium ◯ Low MPOD Score_____ R/L <.25 .25-.45 > .45