



Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient History Questionnaire 1/2

DEMOGRAPHICS									
Last name:			First name:				MI:		
Address:					City/St:		Zip:		
DOB:		SS #:		Email:					
<input type="checkbox"/> Cell same as home		Cell:		Work:		Home:			
Would you like to have online access to your health records? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Occupation:			Employer:				<input type="checkbox"/> Full time <input type="checkbox"/> Part time		
Emergency Contact:					Contact #:				
How did you hear about us:					Referred by?				
Date of last eye exam?				Dr's name:					
Race: <input type="checkbox"/> Asian <input type="checkbox"/> African American/Black <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Unknown/Other:									
Ethnicities: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Other: <input type="checkbox"/> Decline Race & Ethnicities									
INSURANCE INFORMATION:									
Main Insured:				Main SS#:			Main DOB:		
Medical:					Medical ID#:				
Vision Insurance:		<input type="checkbox"/> Advantica <input type="checkbox"/> Always Vision <input type="checkbox"/> Davis <input type="checkbox"/> Health Scope <input type="checkbox"/> Envolve <input type="checkbox"/> Eyemed <input type="checkbox"/> NVA <input type="checkbox"/> Spectra <input type="checkbox"/> Superior <input type="checkbox"/> UHC <input type="checkbox"/> VSP <input type="checkbox"/> VBA <input type="checkbox"/> Eyequest <input type="checkbox"/> Humana Other: _____							
Vision ID#:			<input type="checkbox"/> Primary Member on Vision and Medical						

FAMILY HEALTH HISTORY:									
<b>High Blood Pressure</b>	Yes	No	<b>Relationship:</b>	Father	Mother	Bro.	Sis.	Son	Daughter
<b>Macular Degeneration</b>	Yes	No	<b>Relationship:</b>	Father	Mother	Bro.	Sis.	Son	Daughter
<b>Retinal Detachment</b>	Yes	No	<b>Relationship:</b>	Father	Mother	Bro.	Sis.	Son	Daughter
<b>Diabetes/Type: __ -</b>	Yes	No	<b>Relationship:</b>	Father	Mother	Bro.	Sis.	Son	Daughter
<b>Cataracts</b>	Yes	No	<b>Relationship:</b>	Father	Mother	Bro.	Sis.	Son	Daughter
<b>Cancer</b>	Yes	No	<b>Relationship:</b>	Father	Mother	Bro.	Sis.	Son	Daughter



Hypo/HyperThyro	Yes	No	Relationship:	Father	Mother	Bro.	Sis.	Son	Daughter
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**Patient History Questionnaire 2/2**

PERSONAL MEDICAL HISTORY:									
Height:			Weight:			What is your general Health?			
<b>DO YOU HAVE ANY PROBLEMS WITH? ( Circle Yes/No )</b>									
<b>Eyes</b>	Yes	No	<b>Gastrointestinal</b>	Yes	No	<b>Integumentary (Skin)</b>	Yes	No	
<b>Ear/Nose/Throat</b>	Yes	No	<b>Urinary</b>	Yes	No	<b>Cardiovascular</b>	Yes	No	
<b>Endocrine (Glands)</b>	Yes	No	<b>Respiratory</b>	Yes	No	<b>Blood/Lymph</b>	Yes	No	
<b>High Blood Pressure</b>	Yes	No	<b>Allergies</b>	Yes	No	<b>Nervous System</b>	Yes	No	
<b>Headaches</b>	Yes	No	<b>Muscles/Bones</b>	Yes	No	<b>Mental</b>	Yes	No	
Please explain:									
<b>Diabetes</b>	Yes	No	Type:			Date of Diagnosis:			
Current Medications?									
Allergic to:			Reaction:			<b>Latex Allergy</b>	Yes	No	
<b>Operations?</b>	Yes	No	Type?			Date:			
Family Dr. :			Phone:			Fax:			
Date of Last visit:			Date of last tetanus shot:						
EYE CONDITIONS OR PROBLEMS:									
Eye operations:						Date:			
Eye injuries:						Date:			
<b>Macular Degeneration</b>	Yes	No	<b>Glaucoma</b>	Yes	No	<b>Do you wear contacts?</b>	Yes	No	
<b>Blurred Vision</b>	Yes	No	<b>Cataracts</b>	Yes	No	Contact Brand:			
<b>Retinal Detachment</b>	Yes	No	<b>Do you wear glasses?</b>	Yes	No	Type:			
<b>Alcohol</b>	Yes	No	Frequency:			Power Reye:			
<b>Tobacco</b>	Yes	No	Frequency:			Power Leye:			
<b>Illegal Drugs</b>	Yes	No	Frequency:			B.C./DIA:			
<b>Have you traveled outside the U.S within the past 60 days?</b>	Yes	No	<b>Have you traveled outside the State of Missouri within the past 60 days?</b>	Yes	No	<b>Have you traveled to Chicago, Detroit, Nashville, New York, New Jersey, Atlanta or Florida within the past 60 days?</b>	Yes	No	
<b>Have you had any flu symptoms?</b>	Yes	No	<b>Do you have any cough symptoms?</b>	Yes	No	<b>Have you or anyone you have had contact with</b>	Yes	No	



				S		been tested for Covid-19?		
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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 <b><i>SYMPTOMS</i></b> you experience and when they occur:	At Visit		Within last 72 hrs		Within last 3 months	
	Yes	No	Yes	No	Yes	No
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

Report the <b><i>FREQUENCY</i></b> of your Symptoms using the rating listed below:						
	Symptoms	0	1	2	3	4
0 = Never						
1 = Sometimes	Dryness, Grittiness or Scratchiness					
2 = Often	Soreness or Irritation					
3 = Constant	Burning or Watering					
4 = Intolerable	Eye Fatigue					

Report the <b><i>SEVERITY</i></b> of your symptoms using the rating list below:						
	Symptoms	0	1	2	3	4
0 = No Problems						
1 = Tolerable-not perfect, but comfortable	Dryness, Grittiness or Scratchiness					
2 = Uncomfortable-Irritating, but doesn't interfere with day	Soreness or Irritation					
3 = Bothersome-Irritating and interferes with day	Burning or Watering					
4 = Intolerable-unable to perform daily tasks	Eye Fatigue					

Do you use eye drops for lubrication?  No  Yes, Type: \_\_\_\_\_  
 And how often? \_\_\_\_\_

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



**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.

- 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 Hipa compliance on our website under forms.

**SIGNATURE ON FILE**

Date \_\_\_\_\_ Print Name/Guardian \_\_\_\_\_

Signature/Guardian \_\_\_\_\_

Patient Name (if not self): \_\_\_\_\_

**QUANTIFEYE**

MACULAR DEGENERATION RISK FACTORS			
About <i>YOURSELF</i>	Yes	About your <u>FAMILY</u>	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			
<b>PERSONAL TOTAL</b>		<b>+ FAMILY TOTAL</b>	

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  
Initial: \_\_\_\_\_

For Office use only: Personal+Family= \_\_\_\_\_  High  Medium  Low MPOD Score \_\_\_\_\_ R/L <.25 .25-.45 >.45