Optical Expressions

Optical Expressions Patient History Questionnaire

Date:____/____/____

Patient Information

Last Name:_____ **First Name:**_____ **MI:**_____
Nickname:_____**Address:**_____ **State:**_____ **Zip:**_____
DOB:___/_____/_____ **SS#:**_____-_____-_____ **Race:**_____ **Ethnicity:**_____
▢ **Cell same as Home:**(____)_____ **Wk:**(____)_____ **Cell:**(____)_____
Email Address:_____
Occupation:_____ **Employer:**_____
How did you hear about us:_____**Referred by:**_____
Do you want online records: Yes / No
Emergency Contact:_____ **Contact #:** (____)_____
Date of last eye exam:_____/_____/_____ **Were you dilated?** Yes / No

Insurance Information

Main Insured:_____**DOB Main Ins:**___/___/___ **Main Ins SS#:**_____-_____-_____
Medical Insurance:_____
Vision Insurance: _____

Patient Medical Information

Do you have problems with these systems? *(circle yes or no)*

Eyes: Yes / No
Ears/Nose/Throat: Yes / No
Headaches: Yes / No
Nervous system: Yes / No
Mental: Yes / No
Cardiovascular: Yes / No
Skin: Yes / No
Respiratory: Yes / No
Gastrointestinal: Yes / No
Urinary: Yes / No
High Blood Pressure: Yes / No
Blood/Lymph: Yes / No
Muscles/Bones: Yes / No
Endocrine: Yes / No
Diabetes: Yes / No
⌊***Type: 1 / 2***
⌊***Date Diagnosis:***_____
Allergies: Yes / No

Please Explain:_____
Current Medication(s):_____
Allergies to Medications? Yes / No **Which?:**_____ **Reactions:**_____
Other Health Problems:_____
Name of Family Doctor:_____ **Date of last visit:**_____/_____/_____
Family Doctor Phone:_____
Do you have any eye conditions or problems?_____
Have you had any eye operations?_____ Date____/_____/_____
Have you had any eye injuries?_____ Date____/_____/_____

Do you have: (Circle Yes / No)

1. Do you wear contacts? Y / N
Brand: _____
Type: _____
Power/B.C/Dia:_____
_____

2. Do you wear glasses? Y/ N

3. Cataract: Y/ N

4. Glaucoma: Y/ N

5. Retinal Detachment: Y/ N

6. Macular Degeneration: Y/ N

7. How many hrs of screen time?_____

8. Alcohol: Y/ N Freq:_____

9. Tobacco: Y/ N Freq:_____

10. Recreational: Y/ N Freq:_____

Family History: *(Circle Yes / No)* M=Mother F=Father B=Brother S=Sister N=Son D=Daughter

Diabetes: Yes / No Relation:_____Type:_____
High Blood Pressure: Yes / No Relation:_____
Cancer: Yes / No Relation:_____
Hypo/Hyperthyroidism: Yes / No Relation:_____
Glaucoma: Yes / No Relation:_____
Macular Degeneration: Yes / No Relation:_____
Cataracts: Yes / No Relation:_____
Retinal Detachment: Yes / No Relation:_____

Optical *Expressions*

Optical Expressions is proud to provide the latest in retinal imaging.
The OPTOMAP IS OBTAINED ANNUALLY FOR ALL EXAMS.

We now provide imaging of the retina on all patients with a new scanning digital system called Optomap. Prior to Optomap the only way to thoroughly examine the retina was dilaton. *The optomap 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, and ocular 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 sometimes 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 _____ Sign:_____(Guardian or 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-even if you quit/or social/2nd hand		High Blood Pressure	
Glaucoma		Diabetes	
High Blood Pressure		Heart Disease	
Diabetes		**FAMILY TOTAL:**	
Heart Disease			
Cataract			
PERSONAL TOTAL:			

QUANTIFEYE:

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 treatment options are limited; 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

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*