PATIENT HISTORY FORM

NAME_____DOB_____DATE_____

Chief Complain/Reason for my visit:
Location: **Which Eye?**
Quality: **What are you experiencing?**
Severity: **How bad is it?**
Duration: **When did the problem start?**
Timing: **How long does it usually last?**
Context: **In what setting does it occur?**
Modifying Factor: **What makes it better or worse?**
Associated Symptoms: **Other symptoms that occur?**
Treatments: **How have you treated the problem?**

Pharmacy Name: _____ Pharmacy ph#: _____

Pharmacy Location: _____

Referring Optometry_____ Primary Care Doctor_____

Do you have any allergies? □No □Yes

Please list _____

Do you use tobacco, alcohol or recreational drugs? □No □Yes

Please comment _____

Family Medical History – Does anyone in your family have the following?

□Glaucoma □Diabetes □Cross Eyes □Blindness □Cancer □Heart Disease □None

□Other _____

Please list names and doses of all medications you take:			
Medication	**Dosage**	**Medication**	**Dosage**
□ **None**			

List all previous operations/ treatments/ injuries/ illnesses	
Date	**Description**

Additional comments:

REVIEW OF SYSTEMS

NAME_____DOB_____DATE_____

Please check those things which apply to you.

Eyes

□Glasses
□Contacts
□Pain
□Redness
□Discharge
□Tearing
□Itching
□Swelling
□Light Sensitivity
□Floaters
□Double Vision
□Distortion
□Loss of Color
□NONE

Constitutional Problems

□Fatigue
□Fever
□Weight Loss
□Loss of Appetite
□NONE

Cardiovascular

□Chest pain/ Angina
□Heart Attack
□Irregular Heartbeat
□Heart Murmur
□High Blood Pressure
□NONE

Endocrine

□Heat/ Cold Intolerance
□Severe Thirst
□Excessive Hunger
□Infertility
□NONE

Skin and/ or Breast

□Rashes
□Hives
□ Change in Skin Color
□Loss of Hair
□Breast Lumps/ Surgery
□NONE

Ear/Nose/Mouth/ Throat

□Ringing Ears
□Difficulty Hearing
□Difficulty Chewing
□Difficulty Swallowing
□Difficulty Speaking
□Vertigo
□NONE

Gastrointestinal

□Abdominal Pain
□Indigestion
□Nausea/ Vomiting
□Liver Disease
□Diarrhea/ Constipation
□Passing Blood
□Change in Stool Color
□NONE

Neurological

□Stroke
□Epilepsy
□Headaches/ Migraines
□Balance disturbances
□Numbness of extremities
□Tremors
□NONE

Musculoskeletal

□ Arthritis
□ Muscle Cramps/ Spasm
□ Muscle Weakness
□Aching Joints
□Swelling Joints
□NONE

Respiratory

□Asthma
□Emphysema
□Shortness of Breath
□Productive Cough
□Tuberculosis
□NONE

Genitourinary

□Kidney Stone
□Infections
□Burning Urine
□Genital Discharge
□Dialysis
□Altered Menstrual Cycle
□NONE

Psychiatric

□Memory Loss/difficulty
□Poor Concentration
□Sleeplessness
□Early Waking
□Depression
□Anxiety Attacks
□NONE

Diabetes Controlled By

□Diet
□Insulin
□Oral Medication
□NONE

□ HIV Positive
□ Cancer: _____
□ High Cholesterol
□ HIV Positive

PATIENT NAME: _____ DATE OF BIRTH: _____

VISUAL FUNCTION QUESTIONNAIRE

Please Check All That Apply to You

Have you been bothered by:

____Blurry vision

____Hazy vision

____Glare

____Poor night vision

____Seeing in poor or dim light

____Halos

____Seeing rings or stars around lights

____Frequent changes in glasses

Have you noticed difficulty with your vision when you:

____Work at your job

____Manage your home

____Get around in your home

____Watch TV

____Use a computer

____Play golf

____Read labels

____Read price tags

____Shop for groceries

____Drive during daylight hours

____Drive during evening/ night hours

____See traffic signs

____Sew or do crafts

____Enjoy recreation or leisure

____Recognize people

____Other_____

Patient's Signature: _____

Date: _____ Reviewed by: _____

CATARACTS AND YOUR IOL OPTIONS

Medicare and all other insurance companies allow patients to choose from among several new premium lens implants. These new technology lenses, such as the PanOptix and Vivity lenses (corrects vision for all distances: far, computer and up close) and the Toric lens (corrects vision for astigmatism) ARE NOT COVERED BY ANY INSURANCE PLAN, but you still may take advantage of them by paying out of pocket. We will discuss all options during your evaluation.

Monofocal Lens (Standard)

The traditional lens implant corrects your vision for distance only. Unless you have a significant amount of astigmatism, you will likely be able to see well at distance with minimal reliance on glasses. However, your reading and computer range of vision will most likely be completely blurred and you will need reading glasses. Typically, Medicare and private insurance pays 80% of your surgery with this lens implant. Supplemental insurance may cover a good portion of the rest. There is often a balance related to any unmet deductible that will be collected on the day of surgery.

Astigmatism Lens (Toric)

The Toric Lens is for patients with astigmatism who would like to be able to see as clearly as possible in the distance (Driving, TV) without relying on glasses. You will still need reading glasses and won't see well for reading or computer without them. This lens is not covered by insurance but you are allowed to pay the difference to upgrade to this technology to have your astigmatism corrected with your intraocular lens.

Presbyopia Correcting Lens (PanOptix and Vivity)

The Presbyopia Correcting Lens is for those patients who would like less dependence on glasses. They should provide good vision at all ranges for most people. Our experience is hat PanOptix may provide better near vision, but may experience mild halos around lights at night. Vivity patients do not experience halos around lights at night, but may not obtain as good near vision. There may still be situations such as reading in dim light, reading small print, or driving where glasses are necessary for both lenses. Medicare and other insurance companies do not cover this lens but do allow you to pay for the upgrade. This can be discussed in detail with your doctor and staff if you are interested.

Please let us know if you would like to discuss the new technology lenses with your Surgeon.

__ Yes, I would be interested in learning more about the new technology lenses mentioned above. I understand they are not covered by insurance.

__No, I want just the standard lens that is covered by insurance.

Signature _____ **Date**_____