

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
<input type="checkbox"/> None			

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

Additional comments:

REVIEW OF SYSTEMS

NAME _____ DOB _____ DATE _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PH/CELLULAR#: _____ SOCIAL SECURITY: _____

WEIGHT: _____ HEIGHT: _____

Please check those things which apply to you.

Eyes <input type="checkbox"/> Glasses <input type="checkbox"/> Redness <input type="checkbox"/> Itching <input type="checkbox"/> Floaters <input type="checkbox"/> Loss of Color <input type="checkbox"/> Contacts <input type="checkbox"/> Discharge <input type="checkbox"/> Swelling <input type="checkbox"/> Double Vision <input type="checkbox"/> NONE <input type="checkbox"/> Pain <input type="checkbox"/> Tearing <input type="checkbox"/> Light Sensitivity <input type="checkbox"/> Distortion		
Constitutional Problems <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> NONE	Cardiovascular <input type="checkbox"/> Chest pain/ Angina <input type="checkbox"/> NONE <input type="checkbox"/> Heart Attack <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Heart Murmur <input type="checkbox"/> High Blood Pressure	Endocrine <input type="checkbox"/> Heat/ Cold Intolerance <input type="checkbox"/> Severe Thirst <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Infertility <input type="checkbox"/> NONE
Skin and/ or Breast <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Change in Skin Color <input type="checkbox"/> Loss of Hair <input type="checkbox"/> Breast Lumps/ Surgery <input type="checkbox"/> NONE	Ear/Nose/Mouth/ Throat <input type="checkbox"/> Ringing Ears <input type="checkbox"/> Difficulty Hearing <input type="checkbox"/> Difficulty Chewing <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Difficulty Speaking <input type="checkbox"/> Vertigo <input type="checkbox"/> NONE	Gastrointestinal <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> NONE <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea/ Vomiting <input type="checkbox"/> Liver Disease <input type="checkbox"/> Diarrhea/ Constipation <input type="checkbox"/> Passing Blood <input type="checkbox"/> Change in Stool Color
Neurological <input type="checkbox"/> Stroke <input type="checkbox"/> NONE <input type="checkbox"/> Epilepsy <input type="checkbox"/> Headaches/ Migraines <input type="checkbox"/> Balance disturbances <input type="checkbox"/> Numbness of extremities <input type="checkbox"/> Tremors	Musculoskeletal <input type="checkbox"/> Arthritis <input type="checkbox"/> Muscle Cramps/ Spasm <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Aching Joints <input type="checkbox"/> Swelling Joints <input type="checkbox"/> NONE	Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Productive Cough <input type="checkbox"/> Tuberculosis <input type="checkbox"/> NONE
Genitourinary <input type="checkbox"/> Kidney Stone <input type="checkbox"/> Infections <input type="checkbox"/> Burning Urine <input type="checkbox"/> Genital Discharge <input type="checkbox"/> Dialysis <input type="checkbox"/> Altered Menstrual Cycle <input type="checkbox"/> NONE	Psychiatric <input type="checkbox"/> Memory Loss/difficulty <input type="checkbox"/> Poor Concentration <input type="checkbox"/> Sleeplessness <input type="checkbox"/> Early Waking <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety Attacks <input type="checkbox"/> NONE	Diabetes Controlled By <input type="checkbox"/> Diet <input type="checkbox"/> Insulin <input type="checkbox"/> Oral Medication <input type="checkbox"/> NONE <input type="checkbox"/> Cancer: _____ <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive

FOR OFFICE USE ONLY

REVIEW OF SYSTEM/PHYSICAL EXAMINATION

WEIGHT: _____ HEIGHT: _____ AIR SaQ: _____ B/P: _____ P: _____ R: _____

AIRWAY

WNL CONTACT LENSES CHIPPED, BROKEN, LOOSE TEETH CAPS PLATES BRIDGE DENTURES upper lower both

RISK ASSESSMENT:

APPROPRIATE FOR AMBULATORY SURGICAL SETTING: _____

VITAL SIGNS: WNL Yes _____ other _____

HEART AND LUNGS CTA _____ other _____

No changes or risks to procedure or anesthesia _____

Other _____

PATIENT/GUARDIAN	NPD STATUS
<input type="checkbox"/> Informed of Anesthetic Options/Risk and Consents <input type="checkbox"/> Refused to Discuss Anesthesia Options Risks <input type="checkbox"/> Anesthetic Risks/Options Discussed with Guardian	MEDS

OTHER	NECK EXT	MP SCORE	AIRWAY PROBLEM <input type="checkbox"/> NONE
PRE-ANESTHESIA STATE <input type="checkbox"/> AWAKE <input type="checkbox"/> CALM <input type="checkbox"/> APPREHENSIVE <input type="checkbox"/> UNCOOPERATIVE <input type="checkbox"/> CONFUSED <input type="checkbox"/> ANXIOUS ASA			
SIGNATURE of _____	date/time _____	CRNA SIGN _____	MD SIGN _____

TIME: _____

DATE: _____

INITIALS: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

VISUAL FUNCTION QUESTIONNAIRE

Please Check All That Apply to You

Have you been bothered by:

___ Blurry vision

___ Seeing in poor or dim light

___ Hazy vision

___ Halos

___ Glare

___ Seeing rings or stars around lights

___ Poor night vision

___ Frequent changes in glasses

Have you noticed difficulty with your vision when you:

___ Work at your job

___ Shop for groceries

___ Manage your home

___ Drive during daylight hours

___ Get around in your home

___ Drive during evening/ night hours

___ Watch TV

___ See traffic signs

___ Use a computer

___ Sew or do crafts

___ Play golf

___ Enjoy recreation or leisure

___ Read labels

___ Recognize people

___ Read price tags

___ 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 that 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 _____