InView Eye Care

Patient Registration and History QUESTIONNAIRE

Patient Name: Vision Plan: Medical Plan:

Address: City: State/Zip Code:

Email: Home/Cell: DOB:

Employer/School: Occupation/Grade:

Communication Preference: ❒ Phone ❒ Email Gender:

Notice of Privacy Practices:

I hereby acknowledge that I received a copy of Parkside Eye Care's Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights I may contact the office.

Patient/Legal Guardian Signature X_____ **Date**_____

Acknowledgement of Financial Responsibility

I hereby authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Parkside Eye Care or my insurance company to release any information required to process my claims. I agree to pay any non-covered services not paid by my insurance company.

Patient/Legal Guardian Signature X_____ **Date**_____

Comprehensive Exam with Pupil Dilation

It is an integral part of a comprehensive eye examination to put drops in your eyes to make your pupils larger. A thorough exam with dilation along with additional testing is often the first step in diagnosing a condition that could possibly have devastating effects on your vision. It grants doctors a larger view of the inside of your eye so that they can evaluate the periphery of the retina. We look for tumors, retinal detachments, macular degeneration, and other diseases or defects. The effects of dilation will last 3-4 hours, will affect your near vision, and will increase sensitivity to light. **An additional fee will apply for patients not using insurance.**

❒ I accept dilation today ❒ I want to reschedule dilation ❒ I decline dilation because I am **pregnant** or **nursing**
❒ I decline dilation and accept responsibility for any conditions that may be missed

Patient/Legal Guardian Signature X_____ **Date**_____

Wellness Screening with Retinal Photography

The Wellness Screening is the eye's equivalent of an MRI or CT scan along with a high resolution photograph of your retina. There is no radiation and the procedure is painless because nothing touches your eye. The report helps the doctor diagnose vision threatening diseases like glaucoma, macular degeneration, tumors, and diabetic or hypertensive retinopathy. **For this reason, Dr. Ma and Dr. Reynon highly recommend that all patients have their Wellness Screening**. **It is especially important for people who have a family or personal history of diabetes, high blood pressure, high cholesterol, glaucoma, floaters, flashing light streaks or other ocular problems. This extraordinarily advanced procedure is only $39 if it is elective or not covered by insurance.** It should be noted that the high resolution digital images do not replace dilation, however, in many cases pupil dilation is not needed to obtain the pictures. **Wellness screening with retinal photography is a great tool to use in addition to dilation when a patient can't, or doesn't want to be dilated.**

❒ I accept Wellness Screening with Retinal Photos ❒ I decline Wellness Screening with Retinal Photos to be taken today

Patient/Legal Guardian Signature X_____ **Date**_____

PATIENT HISTORY

Patient's Name _____ Age_____ Height_____ Weight_____

Ethnicity ❒ White ❒ African American ❒ Asian ❒ American Indian ❒Hispanic ❒Native Hawaiian/ Pacific Islander ❒_____

Date of last exam _____ Doctor's Name _____

Reason for Today's Visit

- ❒ First Eye Exam with any Optometrist
- ❒ Annual Check-up; ❒ No Ocular or Visual Complaints
- ❒ Distance Vision is Worse
- ❒ Near Vision is Worse
- ❒ Replace Lost or Broken Spectacles
- ❒ Need More Contact Lenses
- ❒ Would Like to Try Contact Lenses for the First Time
- ❒ Other _____

Eye Conditions/Ocular History

Have you ever been diagnosed with any of the following conditions?

- ❒ Cataracts
- ❒ Age-related Macular Degeneration
- ❒ Glaucoma
- ❒ Diabetes
- ❒ Dry Eye
- ❒ Eye infection, inflammation, or allergy
- ❒ Floaters and/or flashes of light
- ❒ Iritis or Uveitis
- ❒ Retina defects or degenerations
- ❒ Other _____

Eye Concerns

Are you having any of the following concerns?

- ❒ Redness
- ❒ Burning
- ❒ Itching
- ❒ Tearing
- ❒ Discharge

Family Medical History

	Whom?
❒ Thyroid	_____
❒ Cancer	_____
❒ Diabetes	_____
❒ Hypertension	_____

Vision Concerns

Are you having any of the following vision concerns?

- ❒ Blurred vision
- ❒ Eyestrain
- ❒ Eye pain
- ❒ Severe Sensitivity to lights
- ❒ Headache
- ❒ Poor night vision
- ❒ Bothersome night glare
- ❒ Double vision
- ❒ Total loss of vision
- ❒ Other _____

Family Ocular History

	Whom?
❒ Glaucoma	_____
❒ Cataracts	_____
❒ Macular Degeneration	_____
❒ Glaucoma Suspect	_____
❒ Severe Myopia	_____
❒ Amblyopia	_____
❒ Strabismus	_____
❒ Severe Hyperopia	_____
❒ Dry Eye	_____
❒ Retinal Detachment	_____
❒ Nystagmus	_____

Social History

Alcohol Use? ❒Yes ❒No

Tobacco Use? ❒Yes ❒No ❒Cigars ❒Cigarettes

Smoking Status ❒Current ❒Former ❒Never

List any Hobbies (for visual assessment)

Contact Lens History

Brand _____

Prescription _____

Replacement Period _____ Hours/Day_____

Review of Systems – Please check all that apply

❒ NO CHANGES

Constitutional	❒ Fatigue Syndrome	❒ Cancer	❒ Developmental Disabilities				
ENT	❒ Sinusitis	❒ Hearing Loss	❒ Laryngitis	❒ Dry Mouth			
Neuro	❒ Epilepsy	❒ MS	❒ Stroke/CVA	❒ Migraine	❒ Cerebral Palsy	❒ Tumor	
Psych	❒ Depression	❒ Bipolar Disorder	❒ Attention Deficit	❒ Anxiety Disorder			
Cardiovascular	❒ Heart Disease	❒ Vascular Disease	❒ **Hypertension**	❒ Stroke/CVA	❒ CHF		
Respiratory	❒Emphysema	❒Chronic Obstruction	❒Sleep Apnea	❒Asthma	❒Bronchitis		
GI	❒Ulcer	❒Colitis	❒Crohn's	❒Celiac Disease	❒Acid Reflux		
GU	❒Kidney Disease	❒Pregnant	❒BPH	❒STD	❒Prostate CA	❒Chlamydia	❒Herpes
Musc/Skel	❒Ank Spondylitis	❒Osteoporosis	❒Gout	❒Arthritis	❒Osteoarthritis	❒Fibromyalgia	❒Musc Dystrophy
Endocrine	❒Thyroid dysfunction	❒Hormonal dysfunction	❒**Type 2 Diabetes**	❒**Type 1 Diabetes**			
Integumentary	❒Rosacea	❒Eczema	❒Herpes Simplex	❒Psoriasis	❒Herpes Zoster		
Heme/Lymph	❒Large volume blood loss		❒Ulcer	❒Anemia	❒**Hypercholesteremia**		
Allergy/Immuno	❒Sjogren's Syndrome	❒Lupus	❒Drug Allergies	❒Rheum Arthritis	❒Environmental Allergies		

List any **prescribed** and **over the counter medications** (including eye drops)

List all allergies to medications

List all food and environmental/seasonal allergies