Wight Eye Care

Demographics

PLEASE PRINT

E-MAIL _____

PATIENT NAME _____ last _____ first _____ middle Init

PATIENT ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ HOME PHONE (_____) _____ WORK PHONE (_____) _____

CELL PHONE (_____) _____

Spouses D.O.B _____ ARE YOU: ☐ MINOR ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE ☐ SEPARATED

S.S. # _____ YOU OR YOUR PARENT'S EMPLOYER _____ OCCUPATION _____

SPOUSE'S OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE (____) _____

IF YOU ARE A STUDENT, NAME OF SCHOOL _____

CITY _____ STATE _____ ZIP _____

LANGUAGE..... ☐ ENGLISH..... ☐ SPANISH..... ☐ OTHER _____

RACE..... ☐ CAUCASIAN..... ☐ AFRICAN AMERICAN..... ☐ HISPANIC/LATINO..... ☐ ASIAN..... ☐ OTHER _____

ETHNICITY..... ☐ HISPANIC OR LATINO..... ☐ NON HISPANIC OR LATINO..... ☐ OTHER _____

I authorize the release of my eye exam information to Health Care Providers ☐ *yes* ☐ *no*

I request that payment of authorized insurance benifits be made either to me or on my behalf to Wight Eye Care (dba. American Vision Center) for any services furnished by that institution. I hereby authorize Wight Eye Care to release any information necessary to complete my claims. I accept responsibility for all charges not covered by insurance or other third party payers.
Patient (or guardian)

_____
Signature

_____
Date

HIPAA

Acknowledgement of Receipt

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have recieved the Notice of Privacy Practices from Wight Eye Care, Dr. Donald E. Wight, O.D.

_____ Signature

_____ Date

If signing as a personal representative, describe relationship to the patient and the source of authority to sign this form:

Review of Systems

Wight Eye Care

PATIENT _____ DATE _____
LAST FIRST MI

Do you currently, or have you ever had any problems listed below.? Please check any items that apply to you.

CONSTITUTIONAL
- ☐ Negative
- ☐ Developemental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other

EARS, NOSE, MOUTH, THROAT
- ☐ Negative
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Allergies/Hayfever
- ☐ Other

NEUROLOGICAL
- ☐ Negative
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke
- ☐ Headaches
- ☐ Other

PSYCHIATRIC
- ☐ Negative
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar
- ☐ Other

CARDIOVASCULAR
- ☐ Negative
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Migraine
- ☐ Other

RESPIRATORY
- ☐ Negative
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other

GASTROINTESTINAL
- ☐ Negative
- ☐ Crohns
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Other

GENITOURINARY (genitals/kidney/bladder)...
- ☐ Negative
- ☐ Kidney Disease
- ☐ Prostate Disease / Cancer
- ☐ STD
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Chlamydia
- ☐ Other

MUSCULAR / SKELETON
- ☐ Negative
- ☐ Arthritis
- ☐ Osteo Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other

INTEGUMETARY (skin)
- ☐ Negative
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex / Cold Sores
- ☐ Herpes Zoster / Shingles
- ☐ Other

ENDOCHRINE
- ☐ Negative
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other

LYMPHATIC / HEMATOLOGIC
- ☐ Negative
- ☐ Anemia
- ☐ Large Volume Blood Loss / Bleeding
- ☐ Ulcer
- ☐ Hypercholesterolemia
- ☐ Other

ALLERGIC / IMMUNOLOGIC
- ☐ Negative
- ☐ Drug Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogrens Syndrome
- ☐ Other

Doctor's Signature _____ Date _____

Wight Eye Care

Patient Name _____
last first middle

Medical P.C.P. _____ Approximate last medical vist _____

Other Medical Drs _____

Allergies to Medications ☐no ☐yes If yes explain: _____

Current Meds List With Approximate Start Dates

_____

_____

_____

Major injuries, surgeries,and hospitalizations _____

_____

_____

Ocular History

☐ Negative.....
☐ Glaucoma Suspect.....
☐ Glaucoma.....
☐ Cataract.....
☐ Age Related Macular Degeneration...
☐ Eye Surgery.....
☐ Patching.....
☐ Inflammatory Disorder.....
☐ Strabismus.....
☐ Amblyopia.....
☐ Retina Hole / Detachment.....
☐ Retinal Degeneration.....
☐ Keratoconus.....
☐ Retinal Hole.....
☐ Retinal Detachment.....
☐ Injury to Eye.....
☐ Stiles or Chalazion.....
☐ Flashes/Floaters in Vision.....
☐ Bulging Eyes.....

Other _____

_____

_____

Are you pregnant and/or nursing? ☐no ☐yes

Do you wear glasses? ☐no ☐yes If yes, how old are your present lenses? _____

Do you wear contacts lenses? ☐no ☐yes If yes, how old are your present lenses? _____

Type of contact lenses: ☐Rigid ☐Soft ☐Ext. Wear ☐Other _____ Do they feel comfortable? ☐yes ☐no

Patient Social History

This is strictly confidential. You may choose to relate this information directly to the Doctor.

☐Yes I would prefer to discuss my social history with the Doctor only.

Do you drive? ☐ no ☐yes If yes, do you have visual problems when driving? Please describe:

_____

Do you use tobacco? ☐ no ☐yes If yes, type, amount, how long: _____

Do you drink alcohol? ☐ no ☐yes If yes, type, amount, how long: _____

Have you ever been exposed to or infected with: ☐Hepatitis ☐Gonorrhea ☐HIV ☐Syphilis ☐Herpes Simplex ☐Chlamydia

Family Medical History

Please note any family history ("blood relations") for the following conditions:

			Relationship to you
Cancer.....	☐ no	☐yes	☐? _____
Diabetes 1.....	☐ no	☐yes	☐? _____
Diabetes 2.....	☐ no	☐yes	☐? _____
	☐ no	☐yes	☐? _____
Kidney Disease.....	☐ no	☐yes	☐? _____
Thyroid Disease.....	☐ no	☐yes	☐? _____
Other _____			☐? _____

Family Ocular History

Cataract.....	☐no	☐yes	☐? _____
Glaucoma.....	☐no	☐yes	☐? _____
Macular Degeneration.....	☐ no	☐yes	☐? _____
Retinal Detachment or Disease....	☐ no	☐yes	☐? _____
Other _____			☐? _____

Dry Eye Questionnaire

Patient Name or ID _____ **Date:** _____

Technician: _____

Have you been diagnosed with Dry Eye Disease or Ocular Surface Disease? ☐ Y ☐ N **When?** _____

Do you have any of the following symptoms?

- ☐ Blurry vision
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Light sensitivity
- ☐ Excess tearing/ watering eyes
- ☐ Tired eyes, eye fatigue
- ☐ Stringy mucus in or around the eyes
- ☐ Foreign body sensation
- ☐ Contact lens discomfort
- ☐ Scratchy feeling of sand of grit in the eye

Have you had any of the following surgeries?

Cataract: ☐ Y ☐ N
Glaucoma: ☐ Y ☐ N
Refractive surgery: ☐ Y ☐ N

Do you use?

- ☐ Contact lenses
- ☐ OTC eye drops such as artificial tears
- ☐ Rx eye drops for Dry Eye Syndrome (*e.g.*, Restasis)
- ☐ Rx eye drops for Glaucoma (*e.g.*, Xalatan, Timolol)
- ☐ Rx eye drops for Allergy (*e.g.*, anti-inflammatory, antihistamine)
- ☐ Nutritional supplements (*e.g.*, flaxseed oil, omega-3)

Are your symptoms related to the following environmental conditions?

- ☐ Windy conditions
- ☐ Places with low humidity (*e.g.*, airplanes/hospital)
- ☐ Areas that are air conditioned/heated

Are you taking any of the following medications?

- ☐ Antihistamines/decongestants
- ☐ Antidepressant or anti-anxiety
- ☐ Oral corticosteroids
- ☐ Hormone replacement therapy or estrogen
- ☐ Antihypertensives (*e.g.*, diruetic, beta-blocker)
- ☐ Accutane or other oral treatment for acne

Have you ever had punctal occlusion? ☐ Y ☐ N

If the information provided in this form, in conjunction with other clinical data, raises the suspicion of dry eye disease, then obtaining a tear osmolarity test may be indicated.

I reviewed this form and based on the information contained therein and other available clinical data, I suspect that this patient has dry eye disease and obtaining a tear osmolarity measurement is medically necessary for the diagnosis and management of this patient's ocular problem(s).

Attending Clinician: _____ **Date:** _____