EyeCare CONSULTANTS OD/MD

Medical / Surgical EyeCare Specialists

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Welcome to EyeCare Consultants!

At the request of your doctor, we have scheduled an appointment for you on _____. Depending on the reason for your visit, we have set aside approximately 1 1/2 to 3 hours so we can do a complete and thorough exam. Your eyes may be dilated. If you are not comfortable driving dilated you may need someone to drive you to and from your appointment.

Please take a few moments and completely fill out the attached forms. These forms will assist us in providing you the best possible care. Please bring your Driver's License, or Picture ID, and all of your Medical Insurance Cards. You may use the medication form attached or bring a list of all the medications you are currently taking, their dosages, and any medications that you may be allergic to. Please bring your paperwork with you and arrive 20 minutes prior to your scheduled appointment time to allow us to input your information and talk with you about your insurance benefits.

It is our policy to collect all co-pays, co-insurance, and deductibles at the time of service. If you do not have insurance or we do not have a contractual agreement with your insurance company, we will collect payment in full at time of service unless prior arrangements have been made. We accept Cash, Check, Visa, MasterCard, and Discover.

Due to Indiana Law, if you have a legal Power of Attorney who makes your medical decisions, we are required to obtain their consent to treat you and bill your insurance. Please make sure your Power of Attorney is either with you or that we are able to reach them by phone prior to your appointment. Also, if possible, bring a copy of the legal documents so that we may keep documentation in your medical record.

Due to new government regulation, we must inform you, that our physicians have partial ownership in EyeCare Consultants Surgery Center. You will be given a form the day of your appointment entitled "Patient's Rights and Notification of Physicians Ownership" to sign.

If you are unable to keep your scheduled appointment please call our office to cancel at least 24 hours before your appointment. If you have any questions please contact our office. We look forward to assisting you with your eye care needs.

Thank you for choosing EyeCare Consultants!

EyeCare Consultants

PATIENT INFORMATION SHEET

PATIENT INFORMATION

Last Name:	First Name:								M.I.	
Social Security #:	Date of Birth:	Marital Status:	S	M	W	D	SEP	Male	Female	
Street Address:	City:		State:		Zip:					
Home Phone: ( )	Work Phone: ( )	Ext:	Cell Phone: ( )							
Employer:	Occupation:	Personal Email:								
Employer Address:	City:	State:	Zip:							

INSURANCE HOLDER INFORMATION

Last Name:	First Name:								M.I.	
Social Security #:	Date of Birth:	Marital Status:	S	M	W	D	SEP	Male	Female	
Street Address:	City:		State:		Zip:					
Home Phone: ( )	Work Phone: ( )	Ext:	Cell Phone: ( )							
Employer:	Occupation:	Personal Email:								
Employer Address:	City:	State:	Zip:							
Relationship to Patient:										

SPOUSE or PARENT or RESPONSIBLE PARTY INFORMATION

Last Name:	First Name:								M.I.	
Social Security #:	Date of Birth:	Marital Status:	S	M	W	D	Sep	Male	Female	
Street Address:	City:		State:		Zip:					
Home Phone: ( )	Work Phone: ( )	Ext:	Cell Phone: ( )							
Employer:	Occupation:	Personal Email:								
Employer Address:	City:	State:	Zip:							
Relationship to Patient:										

PERSON TO CONTACT IN CASE OF AN EMERGENCY (OTHER than Spouse)

Last Name:	First Name:			M.I.
Home Phone: ( )	Work Phone: ( )	Ext:	Cell Phone: ( )	
Relationship to Patient:				

DOCTOR INFORMATION

Optometrist:	Family Doctor:

SECURITY QUESTION (Please choose ONE from the following)

1. What is your Mother's Maiden Name?
2. What is the Name of the City where you were Born?
3. What is the name of the High School you attended?
4. What is the Name of your Favorite Pet?

TODAY'S DATE: _____ CHART ID: _____ Page 1 of _____

NAME: _____ HEIGHT: _____ WEIGHT: _____ Referring Dr: _____

BIRTHDATE: _____ AGE: _____ SEX: _____ RACE: _____ Primary Care Dr: _____

Are you a new patient? **Y** or **N** (Please circle response)

If "No", has your medical history changed since your last visit? **Y** or **N** ? Date of last eye exam: _____ Dr: _____

List any surgeries you have had (Cataract, Tonsils, Appendix, etc.):

_____

_____

_____

_____

SOCIAL HISTORY:

Are You: Single Married Widowed Divorced

Employed Retired Other: _____

Occupation: _____

Smoking Status: Current Former Never E-cigarette / Vape

Drink alcohol? **Y** or **N**

Drinks per day or week? _____

Do you currently have any problems in the following areas?
If "Yes", Please provide information.

1. General (Fever, Weight Loss, etc.)
2. Ear, Nose, Throat (Sinus, Dry Mouth, etc.)
3. Cardiovascular (Heart, Stroke, Blood Pressure, CAD, CHF, etc.)
4. Respiratory (Asthma, Bronchitis, COPD, etc.)
5. Gastrointestinal (Stomach Ulcers,GERD, etc.)
6. Genital, Kidneys, Bladder (Prostate, Incontinence, etc.)
7. Muscles, Bones, Joints (Arthritis, Osteoporosis, etc.)
8. Skin (Warts, Acne, Cancer, etc.)
9. Neurological (Multiple Sclerosis, Tumor, etc.)
10. Psychiatric (Anxiety, Depression, Insomnia, etc.)
11. Endocrine (Diabetes, Thyroid Dysfunction, etc.)
12. Blood / Lymph (High Cholesterol, Anemia, Hep C, HIV/AIDS, etc.)
13. Allergy / Immunologic (Hay Fever, Lupus, Rheumatoid, etc.)

Explanation of Problem: _____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY:
Does anyone in your immediate family have any of the following?
(Circle all that apply and list family member)

Blindness	High Blood Pressure
Glaucoma	Kidney Disease
Arthritis	Lupus
Cancer	Stroke
Diabetes	Thyroid Disease
Heart Disease	Other: _____

Explanation of Problem: _____

_____

_____

_____

Ocular History (Circle all that apply):

Cataract Trauma Glaucoma Macular Degeneration

Lazy Eye Diabetic Retinal Changes Dry Eye Syndrome

Contact Lens Wearer Previous Eye Surgery

Are you a Diabetic?

How long have you been Diabetic? _____

Last HbA1C: _____

Last Blood Sugar: _____

What Pharmacy do you use? (Name and Address)

Local: _____

Mail-Order: _____

Have you ever taken Flomax or Tamsulosin? **Y** or **N**

Are you post-menopausal? **Y** or **N**

If not: Is there any chance you could be pregnant? **Y** or **N**

Have you had your Influenza Vaccine (Flu shot)? **Y** or **N**

Have you had your Pneumonia Vaccine? **Y** or **N**

Have you had any falls in the past year? **Y** or **N**

If yes, any injuries sustained from the fall? **Y** or **N**

Brief Description of your eye problem, and if it is getting worse, better, or fluctuates: _____

_____

_____

_____

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PATIENT MEDICATION LIST

Patient Name: **DOB:** **Date:**

Current Medications that you take. Please INCLUDE all over-the-counter medications, Herbals, & Vitamins.	What is the Dosage for this medicine? (Ex: 25 mg)	How do you take this medicine?	How often do you take this medicine?	What is this medicine prescribed for?

Allergies:	Reactions:	Allergies:	Reactions:

Latex Allergy? ☐ Yes ☐ No Your Reaction to Latex if Allergic:

EyeCare Consultants
VISUAL DISABILITY INVENTORY

NAME (Please Print): _____ DATE: _____ CHART ID: _____

PLEASE REVIEW THE FOLLOWING QUESTIONS AND CIRCLE ALL THAT APPLY

1. MY VISION DECREASES MY QUAILITY OF LIFE THEREFORE I NEED IMPROVED EYESIGHT. Y N

2. READING IMPAIRMENT:

A. Are you able to read the newspaper? Y N
B. Are you able to read the mail? Y N
C. Are you able to read the Bible? Y N
D. Are you able to read medicine bottles? Y N
E. Do you frequently need a magnifier? Y N
F. Are you having difficulty seeing to write checks or pay bills? Y N
G. Do you need plenty of light to read? Y N

3. HOUSEHOLD ACTIVITIES:

A. While cooking are you able to see the stove, knobs, labels and/or recipes? Y N
B. Are you having difficulty climbing stairs and/or holding on to the banister? Y N
C. Are you having difficulty walking and/or unable to see uneven pavement? Y N
D. Do you have frequent falls? Y N
E. Do you have difficulty shaving? Y N
F. Do you have difficulty bathing? Y N
G. Do you have difficulty washing dishes? Y N
H. Do you have difficulty cleaning house? Y N
I. Do you have difficulty performing yard work? Y N
J. Do you have difficulty caring for your family? Y N
K. Do you have difficulty getting to the doctor? Y N
L. Do you have difficulty shopping? Y N
M. Do you live alone? Y N

4. DRIVING:

A. Daytime: Are you bothered by the sun's glare? Y N
B. Nighttime: Are you bothered by headlights from oncoming cars? Y N
C. Dusk: Is it difficult to discern details? Y N
D. Do you have difficulty with depth perception? perception? Y N
E. Do you have difficulty seeing the driveway? Y N

5. RECOGNITION:

Are you able to recognize people? Y N

6. HOBBIES:

A. Do you sew? Y N
B. Do you collect stamps? Y N
C. Do you garden? Y N
D. Do you collect coins? Y N
E. Are you active in sports? Y N
F. Do you do your own lawn care? Y N
G. Do you watch a lot of TV? Y N
F. Do you participate in any other hobbies or recreation? _____

7. EMPLOYMENT:

A. Are you able to perform your job? Y N
B. Are you at risk for injury at your job? Y N
C. Can you drive to work? Y N
D. If YES to any of the above, please describe your occupation: _____

8. DOUBLE VISION:

Do you ever see double? Y N

9. DIFFERENT IMAGE SIZES:

Do items look the same size to you regardless of which eye you're looking out of? Y N

SIGNATURE: _____

SPEED QUESTIONAIRE

Name: _____ **Date:** _____

DOB: _____ **Sex:** ☐ Male ☐ Female

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionaire,
Please answer the following questions by checking the box that best represents your answer.
Select only one answer per question.

1. Report the type of *SYMPTOMS* you experience and when they occur:

Symptoms:	At this Visit		Within the Past 72 Hours		Within the Past 3 Months	
	YES	NO	YES	NO	YES	NO
Dryness, Grittiness, or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the *FREQUENCY* of your symptoms using the rating list below:

Symptoms:	Never	Sometimes	Often	Constant
	0	1	2	3
Dryness, Grittiness, or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

3. Report the *SEVERITY* of your symptoms using the rating list below:

Symptoms:	No Problems	Tolerable: not perfect, but not uncomfortable	Uncomfortable: irritating, but does not interfere with my day	Bothersome: irritating and interferes with my day	Intolerable: unable to perform my daily tasks
	0	1	2	3	4
Dryness, Grittiness, or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

4. Do you use eye drops for lubrication? ☐ YES ☐ NO **If yes, how often?** _____

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