NAME (Please Print)	First Name M.I. Last Name	DATE of BIRTH	/ /

- YOUR HEALTH HISTORY -

(PLEASE COMPLETE ALL PAGES)

Exam Date:_____,20_____

PRESCRIPTIONS DRUGS MEDICATIONS NAMES ONLY	Please Print Dosages and Frequency ARE Necessary
☐ NO PRESCRIPTION MEDICATIONS TAKEN	
1.	9.
2.	10.
3.	PRESCRIPTION EYE DROPS Dosages and Frequency ARE Necessary
4. PLEASE PRINT	
5.	1.
6.	2.
7.	3.
8.	4.
VITAMINS, SUPPLEMENTS and OVER-THE-COUNTER MEDICATIONS	
☐ NONE TAKEN	3.
1.	4.
2.	5.

ALLERGIES to ...	☐ NONE KNOWN
DRUG ALLERGIES	
	PLEASE PRINT
EYE DROP ALLERGIES	
OTHER ALLERGIES	

Do You or Did You Have ... Please ☑ the BOX or Print			
Diabetes ?	☐	**Multiple Sclerosis ?**	☐
High Blood Pressure ?	☐	**Stroke or "Mini-Stroke" ?**	☐
Heart Disease ?	☐	**COPD** Emphysema, Asthma, Bronchitis **?**	☐
Cancer ?	PLEASE PRINT		
Other ?			

YOUR PRIMARY CARE DOCTOR With Contact Information?
Dr. PLEASE PRINT
Would You Like a Report Sent to Another Doctor ? (Include City)
Dr.

Please ☑ the BOX if It Applies

REVIEW of SYMPTOMS		DOCTOR'S NOTES
I am in GOOD HEALTH	☐	Do Not Write Here
I (Cardiac) Chest Pain or Discomfort ?	☐	
Irregular Heart Beat ?	☐	
II (Pulmonary) Shortness of Breath ?	☐	
Wheezing (Asthma) ?	☐	
Chronic Cough ?	☐	
III (CNS) Headache or Migraines ?	☐	
Seizures or Tremors ?	☐	
Memory Problems ?	☐	
Muscle Weakness, Paralysis ?	☐	
IV (Musculo-Skeletal) Arm or Leg Joint Pain ?	☐	
Neck or Back Pain ?	☐	
V (Endocrine) Weight Gain or Loss ?	☐	
Heat or Cold Intolerance ?	☐	
Excessive Thirst, Urination ?	☐	
VI (Integumentary) Rashes, Blisters ?	☐	
Dry, Scaly Skin (Eczema) ?	☐	
Rosacea (Acne Rosacea) ?	☐	
VII (Hematologic) Bleeding and Bruising ?	☐	
Frequent Colds, Infections ?	☐	
VIII (GI) Diarrhea ?	☐	
Heartburn, Reflux Disease ?	☐	
IX (GU) Pain, Burning on Urination ?	☐	

myfed25@msn.commyfed25@msn.com

EYE HISTORY

Please Print

Do YOU Have or Been Treated For ...	Please ☑ the BOX if It Applies		
Glaucoma	☐	Crossed or "Wall" Eyes	☐
Cataract	☐	Lazy Eye, Amblyopia	☐
Macular Degeneration	☐	Iritis	☐
Keratoconus	☐	Retinal Detachment	☐
OTHER	PLEASE PRINT		

EYE SURGERY

Did YOU Have Surgery (for) ...

Glaucoma ?	☐	Retinal Detachment ?	☐
Cataract ?	☐	Laser for Diabetes ?	☐
LASIK or R.K. ?	☐	Other Eye Laser ?	☐
OTHER	PLEASE PRINT		

INJURIES

Eyes ?	☐	Concussion ?	☐
Facial Fractures ?	☐	Broken Nose ?	☐

CORRECTIVE LENSES

Do YOU Wear ...

Glasses ?	☐	Gas Permeable Lenses ?	☐
Contact Lenses ?	☐	Monovision Contacts ?	☐

FAMILY EYE HISTORY

(Blood Relatives Only)

Glaucoma	☐	Crossed or "Wall" Eyes	☐
Cataract	☐	Night Blindness	☐
Macular Degeneration	☐	Color Blindness	☐
"Lazy" Eye or Amblyopia	☐	Blindness	☐

YOUR FAMILY HEALTH

Diabetes	☐	High Blood Pressure	☐

DOCTOR'S NOTES

Do Not Write Here

ADDITIONAL MEDICAL HISTORY

Please Print

Do You Have or Been Treated For ... Please ☑ the **BOX** if It Applies

Rheumatoid Arthritis ?	☐	Lupus ?	☐
Parkinson's Syndrome ?	☐	Depression ?	☐
Thyroid Disease ?	☐	Kidney Stones ?	☐
"Poor Circulation" ?	☐	H.I.V. or AIDS ?	☐

OTHER : PLEASE PRINT

CANCER (Type?): PLEASE PRINT

Chemotherapy ? ☐	Radiation Therapy ? ☐	Cancer Surgery ? ☐

MAJOR SURGERY (Other Than Eye Surgery)

HEART (e.g. Stent, Valve Repair, Bypass, Pacemaker)	☐	BREAST	☐
ORTHOPAEDIC (e.g. Hip, Knee, Shoulder, Spine)	☐	COLON	☐
GYNECOLOGIC (e.g. Hysterectomy)	☐	BRAIN	☐
UROLOGIC (e.g. Prostate)	☐	CAROTIDS	☐

OTHER: PLEASE PRINT

SOCIAL HISTORY

		DOCTOR'S NOTES
Do You Currently Use Tobacco ?	☐	Do Not Write Here
Have You Ever Used Tobacco ?	☐	
Drink Alcohol ?	☐	
Drive a Car ?	☐	
Live Independently ?	☐	
Live Alone ?	☐	

HOBBIES **(Music, knitting, sports etc.)** PLEASE PRINT

OCCUPATION: EMAIL ADDRESS:

- THANK YOU -

Answer the following questions based on the last week and follow the steps to get your score.
Share the results of where you fall on the Dry Eye Severity Scale with your eye doctor.

A Have you experienced any of the following?

Physical Symptoms	All of the time		Half of the time		None of the time
Eyes that are sensitive to light	4	3	2	1	0
Eyes that feel gritty	4	3	2	1	0
Painful or sore eyes	4	3	2	1	0
Blurred vision	4	3	2	1	0
Poor vision	4	3	2	1	0

A Total ☐

B Have problems with your eyes limited you in performing any of the following?

Daily Symptoms						
Reading	4	3	2	1	0	N/A
Driving at night	4	3	2	1	0	N/A
Working with a computer	4	3	2	1	0	N/A
Watching TV	4	3	2	1	0	N/A

B Total ☐

C Have your eyes felt uncomfortable in any of the following situations?

Environmental Factors						
Windy conditions	4	3	2	1	0	N/A
Places with low humidity (very dry)	4	3	2	1	0	N/A
Areas that are air conditioned	4	3	2	1	0	N/A

C Total ☐

FIND OUT YOUR SCORE →

D Add A, B & C to find D ☐

Locate "D" on the horizontal axis of the Dry Eye Severity Scale

E Total questions answered ☐

N/A does not count as an answered question

Locate "E" on the vertical axis of the Dry Eye Severity Scale

F Dry Eye Score ☐

Where D & E meet is where your score falls on the Dry Eye Severity Scale

Dry Eye Severity Scale

number of all questions answered	normal		mild		moderate					severe
12	10.4	20.8	31.3	41.7	52.1	62.5	72.9	83.3	93.8	100
11	11.4	22.7	34.1	45.5	56.8	68.2	79.5	90.9	100	
10	12.5	25	37.5	50	62.5	75	87.5	100		
9	13.9	27.8	41.7	55.6	69.4	83.3	97.2			
8	15.6	31.3	46.9	62.5	78.1	93.8	100			
7	17.9	35.7	53.6	71.4	89.3	100				
6	20.8	41.7	62.5	83.3	100					
5	25	50	75	100						
	5	10	15	20	25	30	35	40	45	48

sum of scores for all questions answered

Download on the App Store

Download the Dry Eye OSDI® Questionnaire app on your iPhone to easily share your results with your eye doctor and keep track of your score over time.

Excellence in EyeCare, Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

Excellence in EyeCare, Inc. respects your privacy and only uses or discloses your medical information when necessary or appropriate. Our Notice of Privacy Practices describes potential uses and disclosures of your health information by our practice and outlines your medical privacy rights.

Please print your name and sign below indicating you have received our Notice of Privacy Practices. Guarantors are required to sign on behalf of minors.

Patient's Name: (please print) _____

Signature: _____ Date: _____

Please indicate below your preference about our use and disclosure of your health information. Excellence in EyeCare, inc. will release health information to all guarantors of minors and primary care physicians.

☐ I,_____, authorize the person(s) listed below to discuss my care with or receive my health information provided by Excellence in EyeCare, Inc. *(For example, spouse/family memebrs)*

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

☐ I,_____, do not authorize Excellence in EyeCare, Inc. to disclose my health information to any other person except me as the patient.

Excellence in EyeCare, Inc.

Signature on File • Assignment of Benefits • Financial Agreement

I hereby certify that the **insurance information provided by me is <u>correct</u>** and that Excellence in EyeCare, Inc. will file my claim to the insurance company that I provide to the practice. _____
Initial

I request that payment of authorized insurance benefits be made on my behalf to Excellence in EyeCare, Inc. for services provided. I understand that Excellence in EyeCare, Inc. may release information necessary to process my claim.

I understand that I am financially responsible for services that are not covered by my insurance plan. I agree that in return for the services provided, I will pay my account at the time service is rendered or will make arrangements satisfactory to the practice. If my insurance company applies a co-payment or deductible to my visit(s), I agree to promptly pay them to Excellence in EyeCare, Inc. ***However, I understand that I am primarily responsible for the full payment of my bill.***

_____
Initial

I am aware of Excellence in EyeCare's cancellation policy. If I am unable to keep my scheduled appointment I will give a cancellation notice to the office prior to my appointment time or a $30.00 fee may be assessed. I realize a 24-hour notification is much appreciated. _____
Initial

_____
Patient Name (Please Print)

_____ _____
Signature of Patient or Responsible Party Date