

Patient History Questionnaire

Today's Date _____

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name _____ First Name _____ MI _____
 Address _____ City _____ State _____ Zip _____
 Work Phone _____ Home Phone _____
 Date of Birth _____ Occupation _____ Employer _____
 Emergency Contact Name _____ Phone Number _____
 Date of Last Eye Exam _____ Dilated? Yes/No Referred By _____
 Primary Vision Coverage _____ Secondary Coverage _____

Medical Information

email: _____

How is your general health? _____
 Do you take medications for any of these systems? (Please circle yes or no.)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

 Please explain _____
 Diabetes Yes/No _____ Type _____ Date of diagnosis _____
 Allergies to medication Yes/No Which? _____ Reactions? _____
 Other health problems _____
 Current medication(s) _____
 Have you had any operations? Yes/No Kind? _____ When? _____
 Name of family doctor and/or primary care physician _____
 Date of last visit _____ Date your blood pressure was last checked _____

Family History

High blood pressure	Yes/No	Relation _____	Macular degeneration	Yes/No	Relation _____
Diabetes	Yes/No	Relation _____	Retinal detachment	Yes/No	Relation _____
Glaucoma	Yes/No	Relation _____	Cataracts	Yes/No	Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? _____
 Have you had any eye operations? Yes/No Type _____ Date _____
 Have you had an eye injury? Yes/No Kind _____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type _____	

 Additional information _____

Doctor Use Only

Reviewed by _____	<input type="radio"/> No changes	Date _____
Reviewed by _____	<input type="radio"/> No changes	Date _____
Reviewed by _____	<input type="radio"/> No changes	Date _____

GUILDERLAND VISION CARE

Acknowledgement of Receipt of Privacy Policy

I understand that Guilderland Vision Care Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that may occur in my treatment including referrals, payment of my bills, or in the performance of the health care operations of Guilderland Vision Care. Our Notice of Privacy Practices explains our use and disclosure of your Protected Health Information. This notice is posted in the office reception area. I acknowledge that I can receive a copy of this notice upon request.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Guilderland Vision Care has acted in reliance upon this authorization. My written revocation must be submitted to the Practice Manager.

Disclosures

Do we have permission to:

Leave Appointment Information:

On Phone?	[]
Via Email?	[]
On Office Voicemail?	[]
Via Mail?	[]
With Another Person?	[]

Leave Medical Information:

On Phone?	[]
Via Email?	[]
On Office Voicemail?	[]
Via Mail?	[]
With Another Person?	[]

Person(s) Authorized to Communicate With Guilderland Vision Care:

Please understand that we will not be able to release any information about your medical condition to anyone not authorized by you. It is your responsibility to change and/or update this information as necessary.

Printed name (self or legal guardian): _____

Signature _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY POLICY

I understand that Guilderland Vision Care will be billing my insurance company. I also understand that it is my responsibility to read and understand my insurance coverage. If, for any reason, my insurance company does not pay Guilderland Vision Care for services provided, I agree to pay Guilderland Vision Care in full for all services rendered.

Signature _____ Date: _____

Guilderland Vision Care

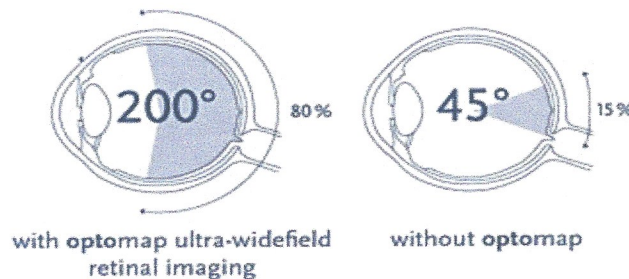


Benefits of an Optomap:

- Early detection of sight-threatening conditions such as glaucoma, macular degeneration, or retinal breaks.
- Early detection of life-threatening diseases like cancer, stroke, or cardiovascular disease.
- A permanent record in your medical file which can provide a baseline to diagnose or track eye conditions.
- Provides a 200° view, with the ability to magnify and add filters that can uncover subtle retinal abnormalities.
- Immediately review results with your doctor.
- Is as fast as taking a picture.
- Does not require dilation, however dilation is part of a comprehensive eye exam and will likely also be recommended.

Early detection means successful treatments can be administered and reduces the risk to your sight and health.

Your insurance is designed to cover only a basic eye exam and does not cover advanced screening tools such as the Optomap. We have invested in this state of the art technology because we believe that it is in our patient's best medical interest to have this retinal scan performed. The Optomap screening fee is **\$39**.



_____ **Yes**, please. I elect to have the **Optomap** performed, so the doctor can optimally assess my retinal health.

_____ I would like more information about Optomap,

_____ **No**, thank you.

DILATION: I would like to be dilated today and understand that driving may be difficult due to sensitivity to light and some blur particularly up close for 4 to 6 hours after instillation of drops. While Optomap is the ideal way to examine the majority of the retina including the macula, optic nerve, and blood vessels, dilation allows for the doctor to see the outermost edge of the retina, and is also highly recommended. _____ **YES** _____ **NO**

Signature: _____