Patient Questionnaire of Optic Dimension, Pllc

Last Name: ______________________ First Name: ______________________ M.I. ______

Birth Date: __________ Age: ______ Sex:______ Marital Status: __________ Phone: ______________

Address: ______________________ City: ______________ State: ______ Zip: ________

Occupation/Employer: ______________ Hobbies: ______________ E-mail: ______________

Insurance Company: ______________________ Insurer Name: ______________________

Insurer Birth Date: ______________ Insurer Last 4 SSN: __________ Insurer Employer: ______________

Last Medical Exam: ______ Where/Doctor: ____________ Last Eye Exam: ______ Where/Doctor: ________

Do you currently wear ○ Glasses ○ Contact Lenses: Soft / Toric / Rigid Brand of contact lenses: ______________

Reason for today's visit: ____

Review of Systems - Please indicate any Personal or Family History below

Allergic/Immune			
Hepatitis/TB/STD/HIV/AIDS/ Shingles	○ Yes		○ No
Lupus/Sarcoidosis	○ Yes		○ No
Cancer	○ Self	○ Family	○ None
Integumentary (Skin)			
Eczema	○ Self	○ Family	○ None
Rosacea	○ Self	○ Family	○ None
Rash, Itching, Pimples, etc.	○ Self	○ Family	○ None
Neurological (Nerves)			
Numbness/Tingling	○ Self	○ Family	○ None
Headaches/Migraines	○ Self	○ Family	○ None
Seizures/Convulsions	○ Self	○ Family	○ None
Light Headed/Dizziness	○ Self	○ Family	○ None
Multiple Sclerosis	○ Self	○ Family	○ None
Ocular (Eyes)			
Blurred Near/Far Vision	○ Yes		○ No
Recent Change in Vision	○ Yes		○ No
Distorted Vision/Halos	○ Yes		○ No
Eye Surgery: Retinal, Cataract, LASIK, Eye Turn, etc.	○ Yes		○ No
Eye Injury	○ Yes		○ No
Flashes/Floaters	○ Yes		○ No
Glare/Light Sensitivity	○ Yes		○ No
Itching/Redness	○ Yes		○ No
Tearing/Watery/Discharge	○ Yes		○ No
Dry/Burning	○ Yes		○ No
Double Vision/Lazy Eye	○ Self	○ Family	○ None
Cataracts	○ Self	○ Family	○ None
Glaucoma	○ Self	○ Family	○ None
Macular Degeneration	○ Self	○ Family	○ None
Retinal Disease	○ Self	○ Family	○ None
Blindness	○ Self	○ Family	○ None
Psychiatric			
Memory Loss/Confusion	○ Self	○ Family	○ None
Anxiety/Depression	○ Self	○ Family	○ None
Violent/Suicidal	○ Self	○ Family	○ None
Bipolar	○ Self	○ Family	○ None
Schizophrenia	○ Self	○ Family	○ None
Ear/Nose/Throat/Mouth			
Swollen Glands in Neck	○ Yes		○ No
Allergies/Hay Fever	○ Yes		○ No
Dry Mouth/Throat	○ Yes		○ No
Sinus Congestion	○ Yes		○ No
Post-Nasal Drip	○ Self	○ Family	○ None
Hearing Loss/Ringing	○ Self	○ Family	○ None
Respiratory (Lungs)			
Asthma/Emphysema	○ Self	○ Family	○ None
Bronchitis	○ Self	○ Family	○ None
COPD	○ Self	○ Family	○ None
Chronic Cough	○ Self	○ Family	○ None
Shortness of Breath	○ Self	○ Family	○ None
Cardiovascular/Vascular (Heart)			
High Cholesterol	○ Self	○ Family	○ None
High Blood Pressure	○ Self	○ Family	○ None
Chest Pain/Heart Attack	○ Self	○ Family	○ None
Stroke/Vascular Disease	○ Self	○ Family	○ None
Gastrointestinal (Stomach/Intestines)			
Diarrhea/Constipation	○ Yes		○ No
Nausea/Vomiting	○ Yes		○ No
Colitis/Crohn's	○ Self	○ Family	○ None
Genitourinary (Kidney/Bladder/Genitals)			
Kidney/Bladder/Genitals	○ Yes		○ No
Frequent Urination	○ Yes		○ No
Bones, Joints, Muscles			
Fibromyalgia	○ Self	○ Family	○ None
Rheumatoid Arthritis	○ Self	○ Family	○ None
Muscle Pain/Weakness	○ Self	○ Family	○ None
Joint Pain/Stiffness/Arthritis	○ Self	○ Family	○ None
Hematologic/Lymphatic (Blood)			
Anemia	○ Self	○ Family	○ None
Bruise Easily	○ Self	○ Family	○ None
Slow to Heal	○ Self	○ Family	○ None
Endocrine			
Diabetes	○ Self	○ Family	○ None
Hormone Changes	○ Self	○ Family	○ None
Thyroid/Other Gland	○ Self	○ Family	○ None

Are You Pregnant? ○ Yes ○ No

Other Conditions not listed for you or your family: ______________________________

Please List All Medications You Currently Take: ______________________________

Please List All Medication Allergies: ______________________________

Social History:

Alcohol Use: Never / Rarely / Moderate / Daily **Tobacco Use**: Never / Quit / # Per Day **Illicit Drug Use**: Never / Type / Frequency

Please List Any Major Injuries, Surgeries, Hospitalizations: ______________________________

Patient Orientated To Person, Place

Doctor's Signature and Date

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status.

Y / N **Reviewed** ______________________

Y / N **Reviewed** ______________________

Y / N **Reviewed** ______________________

Patient Signature ______________ **Date** ________

Updated by ______________ **Date** ________

Updated by ______________ **Date** ________

NAME | **AGE** | **DATE** / / | Insurance: Y / N

Chief Complaint:

______ DFE

______ decline DFE

EM VSP Davis SV
Cigna AAA AARP

XM: ____________________

CL Eval: ____________________

Material Benefit: ____________

Auth #: ____________________

UNAIDED:

OD 20/ OD 20/
OS 20/ OS 20/
FAR NEAR

AIDED: ☐ VA WITH C.L.

OD 20/ OD 20/
OS 20/ OS 20/
FAR NEAR

T **NCT** OD OS

@ ________________

Optos

OD ☐ NAP ☐ See Notes
OS ☐ NAP ☐ See Notes

Lensometry:

OD:

OS:

Contacts:

OD:

OS:

VISUAL FIELDS **CF**

OD ☐ NAP ☐ See Printout
OS ☐ NAP ☐ See Printout

MUSCLE BALANCE
☐ COVER TEST
☐ PHOROPTER

H **FAR** **NEAR**

V **FAR** **NEAR**

EXTRAOCULAR MUSCLES: ☐ FROM

NPS

PUPILS ☐ PERRL - APD

☐ RETINOSCOPY OD

☐ AUTO REFRACTION OS

OD: 20/

OS: 20/

ADD:

20/

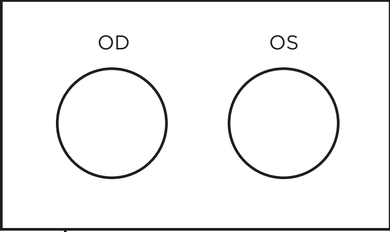
20/

KERATOMETRY:

OD:

OS:

	OD	NAP	OS
LIDS	☐		☐
CONJ	☐		☐
CORNEA	☐		☐
LENS	☐		☐



	OD	NAP	OS
A/C	☐		☐
IRIS	☐		☐
TEARS	☐		☐

ANGLES __________

Contacts Trials / Notes:

	OD	NAP	OS
DISC MARGIN	☐		☐
DISC COLOR	☐		☐
MAC/FOVEA	☐		☐
VESSELS	☐		☐
POST POLE	☐		☐
PERIPHERY	☐		☐

A/V RATIO ________________

OPTIC NERVE	OD	OS
CD	________	________
CUP	________	________
RIM	________	________

☐ MYDRIACYL __________% OU
☐ PHENYLEPRINE 2.5% OU

gtt @

☐ SIDE EFFECTS DISCUSSED LENS:
☐ NO HOLES, BREAKS OR TEARS OU 90D 78D 20D

OU	**REFRACTIVE**	OD	OS
☐	NO REFRACTIVE ERROR	☐	☐
☐	MYOPIA	☐	☐
☐	ASTIGMATISM	☐	☐
☐	HYPEROPIA	☐	☐
☐	PREBYOPIA	☐	☐
☐	Nuclear Cataracts	☐	☐
☐	Cortical Cataracts	☐	☐
☐	PSEUDOPHAKIA (IOL)	☐	☐
☐	AMBLYOPIA	☐	☐

OTHER ________________

BINOCULARITY:
☐ NAP
☐

OCULAR HEALTH:
☐ NAP OU
☐

S1 S2 09 10 One M02 M12 M03

CL1 CL2 CL4 CL6 CLIR M13

OPTO RIS TOPO

FINAL Rx: ☐ SEE ABOVE

OD:

OS:

DOCTOR:

____