VISION SOURCE™

ELLIOTT EYE ASSOCIATES

175 S. Denton Tap Rd. Coppell, Texas 75019 (972) 393-8600 www.elliotteye.com

Eye Health and Lifestyle Questionnaire

Thank you for choosing our office for your eyecare needs. Please complete this form, and don't hesitate to ask for assistance if you have any questions. (Please Print)

PATIENT INFORMATION

Name: _____ Date: ____/____/_____
First MI Last

Phone: (___)____ - _____ Phone (*Cell*): (___)____ - _____ ☐ I prefer to not receive text messages

E-mail Address: _____ ☐ I prefer to not receive emails

Reason for today's visit? _____

Any problems with your current glasses and/or contact lenses? _____

How did you hear about Elliott Eye Associates? ☐ Yellow Pages ☐ Internet ☐ Insurance Company

☐ Patient Referral Whom may we thank for referring you? _____

NOTICE: Please present insurance at the time services are rendered. We cannot accept insurance as payment after services are provided.

EYE HEALTH AND MEDICAL HISTORY

Last Eye Exam: _____ Doctor: _____ Primary Care Physician: _____

(Please Check (✓) any of the following conditions you have or have had in the past)

☐ Blurred Vision – Dist	☐ Floaters	☐ Computer Eyestrain	☐ Retinal Disease
☐ Blurred Vision – Near	☐ Flashes of Light	☐ Dry Eyes	☐ Glaucoma
☐ Recent Eye Infection	☐ Double Vision	☐ Itchy, Watery Eyes	☐ Cataracts
☐ Eye Injury	☐ Loss of Vision	☐ Seasonal Allergies	☐ Asthma
☐ Eye Surgery	☐ Visual Disturbances	☐ Poor Color Vision	☐ Diabetes
☐ Headaches (eye-related)	☐ Sensitivity to Light	☐ Currently Pregnant	☐ High Blood Pressure

List any Medications you are taking: _____

List any Drug Allergies you have: _____

Do you regularly use any of the following? ☐ Tobacco ☐ Alcohol ☐ Illegal Drugs

FAMILY EYE HEALTH HISTORY

(Please Check (✓) if your blood relatives had any of the following and their relationship to you)

☐ Blindness (Relationship: _____) ☐ Glaucoma (Relationship: _____)

☐ Macular Degeneration (Relationship: _____) ☐ Cataracts (Relationship: _____)

☐ Retinal Detachment (Relationship: _____) ☐ Diabetes (Relationship: _____)

LIFESTYLE QUESTIONS

Occupation: _____ If student, what grade? _____

Do you . . . *(check box if you answer yes)*

☐ . . currently have prescription eyewear?

☐ . . spend a lot of time outdoors?

☐ . . currently have prescription sunwear?

☐ . . use a computer on a daily basis? Hours/day? _____

☐ . . currently have computer eyewear?

☐ . . have more than one pair of current eyewear?

☐ . . have interest in "test driving' the contact lenses?

☐ . . want information on Laser Vision Correction?

☐ . . have interest in a non-surgical approach to vision correction (Ortho-K/CRT)?

☐ . . have family members in need of eyecare?

Medical Review Of Systems

Please check if you are currently having any problems in the following areas:

Allergic/Immunological
- *Recurrent Infection* ☐
- *Hay Fever* ☐
- *Hives* ☐

Cardiovascular
- *Elevated Blood Pressure* ☐
- *Chest Pain* ☐
- *Vascular Disease* ☐

Ear/Nose/Throat
- *Chronic Runny Nose* ☐
- *Chronic Cough* ☐
- *Chronic Sinus Congestion* ☐
- *Dry Mouth / Throat* ☐

Endocrine
- *Excess Thirst* ☐
- *Fatigue* ☐
- *Weight Change* ☐

Gastrointestinal
- *Diarrhea* ☐
- *Constipation* ☐

Genitourinary
- *Urinary Frequency* ☐
- *Urinary Discomfort* ☐

Muscles/Bones/Joints
- *Arthritis* ☐
- *Muscle Tenderness* ☐
- *Joint Pain* ☐

Neurological
- *Frequent Headaches* ☐
- *Confusion / Dizziness* ☐
- *Seizures* ☐

Psychiatric
- *Anxiety* ☐
- *Depression* ☐

Respiratory
- *Asthma* ☐
- *Breathing Difficulty* ☐
- *Shortness of Breath* ☐

Skin
- *Itching / Rash* ☐
- *Eczema and/or Rosacea* ☐
- *Recurrent Dermatitis* ☐

If you checked any of the above conditions or if you have a condition not listed, please explain: _____

_____

_____

Consent To Use Or Disclose Health Information For Treatment, Payment And Health Care Operations

We have a comprehensive Notice of Privacy Practices that describes the use and disclosure of your health information. We will not disclose your information for purposes other than for treatment including care and services provided here, and also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. You can get a copy of our privacy practices here at the office or from our web site.

I have been offered a copy of the Notice of Privacy Practices and have been provided an opportunity to review it. I also understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary for treatment and to secure payment of benefits. I authorize the use of this signature on all insurance submissions if necessary.

_____

Signature of Patient/Parent

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iWellness / Optomap Retinal Imaging

We are excited to offer two state-of-the-art digital retinal imaging technologies that allow us to view the inside of your eye without the use of dilation drops and fully examine your eye health. Both the iVue iWellness Exam and the Optomap Retinal Exam will allow us to evaluate your eye health for problems, such as macular degeneration, glaucoma, retinal holes, retinal detachments, hypertension, and diabetic retinopathy. The scanning system is completely safe for children and adults.

iVue / Optomap Retinal Health Exam Benefits

The most comprehensive evaluation of your eye and retinal health
NO dilation which means NO blurred vision and NO light sensitivity
Each test takes less than 1 minute to complete
Permanent, quantifiable digital images that can be reviewed and monitored each year
You get to review your results and discuss them with your doctor

Early Detection Is Crucial!!

Our doctors recommend that ALL patients have this thorough examination of their retina every year. **Without the iVue and Optomap technology, the doctors cannot fully assess the health of your eye.** There is an additional fee of **$49.00** for this eye health evaluation. This procedure will not be covered by insurance unless there is a pre-existing retinal condition or diabetes. Dilation may still be utilized in certain instances.

☐ I elect to have the iWellness / Optomap Retinal Exam today. ($49.00)

☐ I refuse the iWellness / Optomap Retinal Exam and prefer to be dilated. I have been informed of the benefits listed above.

_____

Signature of Patient/Parent