Eye Symptoms Checklist

Please check the symptoms you are currently experiencing.

_____ Burning Eyes
_____ Constant or occasional tearing
_____ Dryness of the eye
_____ Eye pain or soreness
_____ Sensation of foreign matter in eyes
_____ Fluctuating vision
_____ Itching
_____ Lid Infections
_____ Discomfort with bright lights
_____ Redness
_____ Redness after drinking alcohol
_____ Sandy or gritty feeling
_____ Sties
_____ Stringy mucus in or around the eyes
_____ "Tired eyes"
_____ Watering eyes

Related Conditions

_____ Allergies or hay fever
_____ Asthma
_____ Bronchitis
_____ Chronic cough
_____ Dry throat or mouth
_____ Frequent colds
_____ Headaches
_____ Middle ear congestion
_____ Joint / Arthritis pain
_____ Nasal congestion
_____ Post-nasal drip
_____ Runny nose
_____ Sinus congestion
_____ Sleep apnea
_____ C-Pap or Bi Pap
_____ Sneezing

If you wear contact lenses or have worn contact lenses in the past, please answer the following questions:

Yes	No	
_____	_____	Do you currently wear contact lenses?
		If so, how long have you worn them? _____
_____	_____	Are they comfortable?
_____	_____	Are your eyes sensitive to contact lens solution?
_____	_____	Have you worn contact lenses before, and then quit for some reason?
		If so, what factors caused you to quit wearing them? _____
		_____

Are your eyes sensitive to:
(*Please circle **all** that apply.*)

Air Conditioning
Contact Lens Wear
Heaters
Smog
Video Display Terminals
Cigarette Smoke
Dust
Pollen
Sunshine
Wind

Are you pregnant? YES NO

Are you nursing? YES NO

Revised May 2016

Patient History Questionnaire

Please Answer All Questions

Today's Date_____

Last Name _____ First Name _____ MI _____

Address _____ City _____ Zip_____

Gender: M F DOB __/__/____ Occupation_____ Employer_____

Email_____ (will not be shared) Phone/cell _____/_____

SSN _____-____-_____ Child / Single / Widowed / Married Spouses Name: _____

Person Responsible for Payment if different than patient _____

INSURANCE INFORMATION

Primary Insured _____ DOB ____/____/_____ SSN ____-____-_____

Relationship to Patient _____ Employer _____

MEDICAL INFORMATION

How is your general health? _____

Do you currently have problems with any of these systems? *(Please explain if answered yes)*

Gastrointestinal (stomach / intestines)	YES	NO	Ears / Nose / Mouth / Throat	YES	NO
Constitutional (fever / weight loss)	YES	NO	Allergic / Immunologic	YES	NO
Cardiovascular (heart disease / high BP)	YES	NO	Blood / Lymphatic (bleeding / anemia)	YES	NO
Neurological (headaches / migraines / seizures)	YES	NO	Psychiatric (mood changes / depression)	YES	NO
Endocrine (diabetes / thyroid / other glands)	YES	NO	Eyes (see Personal Eye Info below)	YES	NO
Genitourinary (genitals / kidney / bladder)	YES	NO	Integumentary (rash / scaling / dry)	YES	NO
Musculoskeletal (muscle /joint pain/rheum arth)	YES	NO	Respiratory (lungs / breathing / cough)	YES	NO
Autoimmune Disease	YES	NO	Other health problems:_____		

Please answer all that apply:

Diabetes: YES NO Type: _____ Date Diagnosed: _____

Allergies/medication: YES NO Penicillin/Sulfa/Codeine/Other: _____

Cancer: YES NO Type & Treatment: _____

List any operations and approximate dates: _____

_____

Under 18 yo: Developmental/ School Performance Normal / Delayed

Are you pregnant? YES NO Are you nursing? YES NO Exposed to HIV? YES NO

Do you use cigarettes/tobacco? YES NO Alcohol? YES NO Other substances? YES NO

Family History (Blood Relatives)

Diabetes YES NO Relation _____ Macular Degeneration YES NO Relation _____

High BP YES NO Relation _____ Glaucoma YES NO Relation _____

Cataracts YES NO Relation _____ Retinal Detachment YES NO Relation _____

Other eye conditions YES NO Please Explain: _____

Personal Eye Information

Have you ever had Cataract Surgery? YES NO If So, when? Right _____ Left _____

Laser after Cataract Surgery? YES NO If so, when? Right _____ Left _____

Have you had any other eye surgery? YES NO Type? _____ Date? _____

Have you ever had any eye injuries? YES NO Describe: _____

Have you ever had any eye diseases? YES NO Describe: _____

Do you have Glaucoma? YES NO Cataracts? YES NO Dry Eyes? YES NO Blurred Vision? YES NO

Have you ever had crossed eyes? YES NO Lazy eye? YES NO Drooping eyelid? YES NO

Other Eye Problems? _____

Do you wear glasses? YES NO Do you wear contact lenses? YES NO Type: _____

Staff use:

*Updated:*____/____/_____ *No Changes*____ *Tech*____ *Reviewed:*_____

*Updated:*____/____/_____ *No Changes*____ *Tech*____ *Reviewed:*_____

*Updated:*____/____/_____ *No Changes*____ *Tech*____ *Reviewed:*_____

MEDICATION ALLERGIES: _____

_____

MEDICATIONS

PATIENT NAME: _____

DATE REVIEWED	MEDICATION	REASON YOU ARE TAKING	DATE MARKED OFF

Eye care services and products may be covered by two different types of insurance policies.

Vision Plans - such as VSP provide routine vision exams along with benefits for eyeglasses or contact lenses. Vision plans only cover a basic eye health screening for eye disease. These plans DO NOT cover diagnosis, management or treatment of eye diseases or conditions such as dry eye, glaucoma, or annual diabetic eye examinations.

Medical Plans - such as BlueCross/BlueShield, Medicare do not cover routine eye exams, do not cover the refraction (check for glasses prescription), nor do they provide benefits for glasses unless a vision policy is attached. Medical plans will be used if you have an eye health problem or general health problem, which has ocular complications as in diabetes. Dr. Pearson will determine which coverage is appropriate.

If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use *coordination of benefits* to minimize your out of pocket expenses.

Our office will bill your insurance plan for services if we are a participating provider. We will try to obtain advance authorization of your insurance benefits. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, copays or non-covered services as allowed by the insurance contract.

I understand that I am financially responsible for services not covered by my insurance plan(s).

Please check one of the following:
[ ] I have provided to Dr. Pearson my vision and or medical insurance for them to file on my behalf.

[ ] I request Dr. Pearson's office not to file any claims for payment with my insurance plan. I understand that I am financially responsible for payment in full for all services that I receive regardless of the possibility of coverage under my insurance plan.

I further acknowledge that I have been provided Dr. Pearson's **HIPAA Notice of Privacy Practices** and notice of **Dilating Eye Drops** information.

I give consent to **release health information** to: (family member, friend, etc.)

Name_____ [ ] All Records [ ] Medical only [ ] Financial only
Name_____ [ ] All Records [ ] Medical only [ ] Financial only
Name_____ [ ] All Records [ ] Medical only [ ] Financial only

Patient or guardian Signature _____ Date _____