# Medical History Questionnaire

Name: ______________________ Today's Date: ______________________

Address: ______________________ Phone: ______________________

______________________ Work Phone: ______________________

Guardian (If Applicable): ______________________ Occupation: ______________________

Email: ______________________ Preferred Language: ______________________

Birth Date: ____________ Social Security #: ____________ Race/Ethnicity: ______________________

Gender: ____________ Date of Last Eye Exam: ____________ Date of Last Medical Exam: ______________________

Name of Medical Doctor: ______________________ Dr.'s Phone: ______________________

## Medical History

Do you have any allergies to medications? ❐ no ❐ yes If yes, explain: ______________________

______________________

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

______________________

______________________

______________________

List all major injuries, surgeries and/or hospitalizations you have had: ______________________

______________________

Check any of the following that you have had: ❐ crossed eyes ❐ lazy eye ❐ drooping eyelid ❐ prominent eyes ❐ Glaucoma ❐ retinal disease ❐ cataracts ❐ eye infections ❐ eye injury

Are you pregnant or nursing? ❐ no ❐ yes

Do you wear glasses? ❐ no ❐ yes If yes, how old is your present pair of lenses? ____________

Do you wear contact lenses? ❐ no ❐ yes If yes, how old is your present pair of lenses? ____________

Type of contact lenses: ❐ Rigid ❐ Soft ❐ Extended Wear ❐ Other Are they comfortable? ❐ yes ❐ no

**Family History:** note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions.

| Disease/Condition | No | Yes | ? | Relationship To You |
|---|---|---|---|---|
| Blindness | ❐ | ❐ | ❐ | ____________ |
| Cataract | ❐ | ❐ | ❐ | ____________ |
| Crossed Eyes | ❐ | ❐ | ❐ | ____________ |
| Glaucoma | ❐ | ❐ | ❐ | ____________ |
| Macular Degeneration | ❐ | ❐ | ❐ | ____________ |
| Retinal Detachment or Disease | ❐ | ❐ | ❐ | ____________ |
| Arthritis | ❐ | ❐ | ❐ | ____________ |

| Disease/Condition | No | Yes | ? | Relationship To You |
|---|---|---|---|---|
| Cancer | ❐ | ❐ | ❐ | |
| Diabetes | ❐ | ❐ | ❐ | ____________ |
| Heart Disease | ❐ | ❐ | ❐ | ____________ |
| High Blood Pressure | ❐ | ❐ | ❐ | ____________ |
| Kidney Disease | ❐ | ❐ | ❐ | ____________ |
| Lupus | ❐ | ❐ | ❐ | ____________ |
| Thyroid Disease | ❐ | ❐ | ❐ | ____________ |
| Other: ____________ | | | | ____________ |

✳ ***Please Turn This Form Over & Complete Side Two*** ✳

**Social History**: *This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.*

❒ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❒ no ❒ yes If yes, do you have visual difficulty when driving? ❒ no ❒ yes If yes, please describe: ______________________

Do you use tobacco products? ❒ no ❒ yes If yes, type/amount/how long: ______________________

Do you drink alcohol? ❒ no ❒ yes If yes, type/amount/how long: ______________________

Do you use illegal drugs? ❒ no ❒ yes If yes, type/amount/how long: ______________________

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

**Review of Systems:** Do you currently, or have you ever had any problems in the following areas?

| System | NO | YES | ? |
|---|---|---|---|
| **Constitutional** | | | |
| Fever, Weight Loss/Gain | ❒ | ❒ | ❒ |
| **Integumentary** (Skin) | ❒ | ❒ | ❒ |
| **Neurological** | | | |
| Headaches | ❒ | ❒ | ❒ |
| Migraines | ❒ | ❒ | ❒ |
| Seizures | ❒ | ❒ | ❒ |
| **Eyes** | | | |
| Loss of Vision | ❒ | ❒ | ❒ |
| Blurred Vision | ❒ | ❒ | ❒ |
| Distorted Vision/Halos | ❒ | ❒ | ❒ |
| Loss of Side Vision | ❒ | ❒ | ❒ |
| Double Vision | ❒ | ❒ | ❒ |
| Dryness | ❒ | ❒ | ❒ |
| Mucous Discharge | ❒ | ❒ | ❒ |
| Redness | ❒ | ❒ | ❒ |
| Sandy or Gritty Feeling | ❒ | ❒ | ❒ |
| Itching | ❒ | ❒ | ❒ |
| Burning | ❒ | ❒ | ❒ |
| Foreign Body Sensation | ❒ | ❒ | ❒ |
| Excess Tearing/Watering | ❒ | ❒ | ❒ |
| Glare/Light Sensitivity | ❒ | ❒ | ❒ |
| Eye Pain or Soreness | ❒ | ❒ | ❒ |
| Chronic Infection, Eye or Lid | ❒ | ❒ | ❒ |
| Sties or Chalazion | ❒ | ❒ | ❒ |
| Flashes/Floaters in Vision | ❒ | ❒ | ❒ |
| Tired Eyes | ❒ | ❒ | ❒ |
| **Endocrine** | | | |
| Thyroid/Other Glands | ❒ | ❒ | ❒ |

| System | NO | YES | ? |
|---|---|---|---|
| **Ears, Nose, Mouth, Throat** | | | |
| Allergies/Hay Fever | ❒ | ❒ | ❒ |
| Sinus Congestion | ❒ | ❒ | ❒ |
| Runny Nose | ❒ | ❒ | ❒ |
| Post-Nasal Drip | ❒ | ❒ | ❒ |
| Chronic Cough | ❒ | ❒ | ❒ |
| Dry Throat/Mouth | ❒ | ❒ | ❒ |
| **Respiratory** | | | |
| Asthma | ❒ | ❒ | ❒ |
| Chronic Bronchitis | ❒ | ❒ | ❒ |
| Emphysema | ❒ | ❒ | ❒ |
| **Vascular / Cardiovascular** | | | |
| Diabetes | ❒ | ❒ | ❒ |
| Heart Pain | ❒ | ❒ | ❒ |
| High Blood Pressure | ❒ | ❒ | ❒ |
| Vascular Disease | ❒ | ❒ | ❒ |
| **Gastrointestinal** | | | |
| Diarrhea | ❒ | ❒ | ❒ |
| Constipation | ❒ | ❒ | ❒ |
| **Genitourinary** | | | |
| Genitals/Kidney/Bladder | ❒ | ❒ | ❒ |
| **Bones / Joints / Muscles** | | | |
| Rheumatoid Arthritis | ❒ | ❒ | ❒ |
| Muscle Pain | ❒ | ❒ | ❒ |
| Joint Pain | ❒ | ❒ | ❒ |
| **Lymphatic / Hematologic** | | | |
| Anemia | ❒ | ❒ | ❒ |
| Bleeding Problems | ❒ | ❒ | ❒ |
| **Allergic / Immunologic** | ❒ | ❒ | ❒ |
| **Psychiatric** | ❒ | ❒ | ❒ |

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

______________________

______________________

______________________

______________________

______________________ Doctor's Signature

______________________ Date



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## Dr. J Feder is a developmental optometrist, also known as behavioral optometry.

Aside from a routine eye exam, a developmental optometrist looks for problems with visual skills that are related to learning. These visual skills can lead to problems in all aspects of the learning process. More often than not it is as simple as training the eyes and brain to work together. Vision therapy is a type of *physical therapy* for the eyes and brain. If your child is not working up to potential in school there is a strong possibility that a vision problem might be present. According to experts, almost 50% of children with learning difficulties have vision disorders. In most cases problems can be successfully treated leading to improved learning and better grades.

## What is involved in a Vision Therapy programs?

Vision therapy is—

- A progressive program of vision " exercises" or procedures;
- Performed under doctor supervision;
- Individualized to fit the visual needs of each patient;
- Generally conducted in-office, in once or twice weekly sessions of 30 minutes to one hour;
- Sometimes supplemented with procedures done at home between office visits("homework");
- (depending on the case) prescribed to –
  +help patients develop or improve fundamental visual skills and abilities;
  +improve visual comfort, ease, and efficiency;
  +change how a patient processes or interprets visual information.

**We ask that you spend a few minutes and answer the questionnaire attached to this sheet.**

# <u>SYMPTOMS OF BINOCULAR VISION DSYFUNCTION</u>

Have you observed any of the following symptoms with your child, or have they, their teacher, or other family member reported any of them to you? Please <u>mark the symptoms that occur frequently with two checks and those that occur occasionally with one check.</u>

**Be sure to hand this completed checklist to the doctor at the beginning of your consultation.**

1. ____Skips lines while reading or copying
2. ____Loses place while reading or copying
3. ____Substitutes words while reading or copying
5. ____Rereads words or lines
6. ____Reverses letters, numbers or words
7. ____Uses a finger or marker to keep place while reading/writing
8. ____Reads very slowly
9. ____Poor reading comprehension
10. ____Difficulty remembering what has been read
11. ____Holds head too close when reading/writing (within 7-8 in)
12. ____Squints, closes or covers one eye while reading
13. ____Unusual posture/head tilt when reading/writing
14. ____Headaches following intense reading/computer work
15. ____Eyes hurt or feel tired after completing a visual task
16. ____Feels unusually tired after completing a visual task
17. ____Double vision
18. ____Vision blurs at distance when looks up from near work
19. ____Letters or lines "run together" or "jump" when reading
20. ____Print seems to move or go in and out of focus when reading
21. ____Poor spelling skills
22. ____Writing is crooked or poorly spaced
23. ____Misaligns letters or numbers
24. ____Makes errors copying
25. ____Difficulty tracking moving objects
26. ____Unusual clumsiness, poor coordination
27. ____Difficulty with sports involving good eye-hand coordination
28. ____Eye turns in or out
30. ____Feels sleepy while reading
31. ____Dislikes tasks requiring sustained concentration
32. ____Avoids near tasks such as reading
33. ____Confuses right and left directions
34. ____Becomes restless when working at his/her desk
35. ____Tends to lose awareness of surroundings when concentrating
36. ____Must "feel" things to see them
37. ____Carsickness
38. ____Unusual blinking
39. ____Unusual eye rubbing
40. ____Dry eyes
41. ____Watery eyes
42. ____Red eyes
43. ____Eyes bothered by light

*IF NONE APPLY, PLEASE SIGN

X________________________________

## Patient Information

**How did you hear about us?** Welcome Wagon Mailer__ Our Website__ Insurance Website__ Other__

Name: ______________________________ SS#: _____-___-______ DOB: Prim DOB: ___/___/_____

Address: ______________________________ City________________ State: _____ Zip: __________

Home #: ____________________Cell #: ______________________Work #: ______________________

Email:_________________________________________@_______________________________________

Sex: Male / Female Married____ Single____ Divorced ____ Widowed____

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## Vision Benefits

Vision Coverage Plan: _____________________ Prim. SS#: ____-___-_____ Prim DOB: ___/___/_____

Primary name on insurance: _____________________ Relationship to PT: ______________________

- □ Address same as patient

Address: ______________________________ City________________ State: _____ Zip: __________

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## Primary Medical Insurance

Insurance company: __________________________ ID# ___________________ GRP: ____________

Primary name on insurance: _____________________ Prim DOB: ___/___/_____

Relationship to PT: ____________________________

- □ Address same as PT
- □ Address the same as Vision Benefits

Address: ______________________________ City________________ State: _____ Zip: __________

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## Additional Medical Information

Is patient covered by additional insurance? ____Yes ____NO If YES, fill out following:

Insurance company: __________________________ ID# ___________________ GRP: ____________

Primary name on insurance: _____________________ Prim DOB: ___/___/_____

Relationship to PT: ____________________________

- □ Address same as PT
- □ Address the same as Vision Benefits
- □ Address the same as Medical Insurance

Address: ______________________________ City________________ State: _____ Zip: __________

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## Authorization

- I have reviewed the information on this sheet and it is accurate to the best of my knowledge.
- I authorize my insurance company to pay the doctor or medical group all insurance benefits otherwise payable to me for services rendered. **I authorize the use of this signature on all insurance submissions.**
- **<u>I understand that I am financially responsible for all charges whether or not paid by my insurance</u>**. In the event your insurance carrier **DOES NOT COVER** these services, you agree to pay the said fee **PRIVATELY-OUT-OF-POCKET**.
- Medicare and Medical patients are responsible for refractions, deductibles, and or co-payments.
- Appointments missed without a minimum 24 hour notice are subject to a cancellation fee.

Signature _______________________________________ Date ______________________________

Patient Name: ____________________

Date of Birth: ____________________

## Springhouse Eye Care

# Patient Communication Consent Form

I agree to allow Springhouse Eye Care to contact me in the following methods regarding my private health information, evaluation, and treatment. I authorize Springhouse Eye Care to leave messages for me when I am unavailable.

| Method | Number/Address | Messages (Yes or No) |
|---|---|---|
| ____ Home Phone | (____) ____________________ | □ Yes □ No |
| ____ Cell Phone | (____) ____________________ | □ Yes □ No |
| ____ Text Messages | (____) ____________________ | □ Yes □ No |
| ____ Work Phone | (____) ____________________ | □ Yes □ No |
| ____ Email | ______________@__________ | □ Yes □ No |

I authorize Springhouse Eye Care and medical staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment, and other private health information) with the contacts listed below.
**I understand by leaving spaces blank I am indicating my choice to be a *"No Information"* and I do not want any information released to anyone else.**

| Name | Relationship to Patient | Contact Info |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Emergency Contact Only—**
Name: ____________________ Phone: ____________________

**Communication with Other Healthcare Providers:**
Patient information or medical records may be communicated to other healthcare providers, hospitals, or insurance companies if necessary.

By my signature below I acknowledge the risks associated with the different methods of communication, especially e-mail and texting.

______________________________ ______________________________
**Patient Printed Name** **Date**

______________________________ ______________________________
**Patient/Authorized Signature** **Relationship to Patient**