ROTTMAN EYE CARE ICON EYECARE AMY CECIL, OD

A Network Partner Of

EVP EyeCare

-Patient Information-

Today's Date: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Date of Birth: _____ Gender: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____ Opt-in Patient Portal: Y N

Marital Status: _____ Spouse's Name: _____

Reason for Your Visit: _____ Referred By:_____

Primary Care Provider Name and Contact Number: _____

Pharmacy Name and Location: _____

In the event that a family member or caregiver accompanies me at the time of my evaluation and/or treatment, I give my permission to freely discuss my condition, treatment and diagnosis with that person. Initial: _____

Employer: _____ Address: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Parent or Guardian (if patient is under 18) _____

Date of Birth: _____ Relationship: _____ Phone: _____

Parent's Employer: _____

Please list whom we can discuss your diagnosis and treatment with:

Name: _____

Relationship: _____

Name: _____

Relationship:_____

Please list whom we may discuss your financial questions with:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

-INSURANCE INFORMATION-

As a medical office, we only bill medical insurance plans. Vision plans are not accepted
Please bring your photo ID and your insurance cards with you to your appointment

Primary Insurance Company Name: _____

Member ID: _____ Group Number: _____

** If the patient is NOT the subscriber:

Name of Subscriber: _____

Subscriber's relationship to patient:_____

Subscriber's date of birth: _____

Secondary Insurance Company Name: _____

Member ID: _____ Group Number: _____

** If the patient is NOT the subscriber:

Name of Subscriber: _____

Subscriber's relationship to patient:_____

Subscriber's date of birth: _____

-**On the Job Injury-**

Date of Injury: _____ Employer: _____ Phone#: _____

I understand that the charges for services must be paid upon receipt of medical services, I also understand that I am responsible for all my financial obligations as a result of the medical services received.

I hereby authorize EVP EyeCare to provide information to insurance companies concerning the medical services received.

Additionally, I hereby assign all insurance payments related to the claims made by this office, in my benefit and for the benefit of my dependents, to EVP EyeCare. I understand that I am responsible for any adjustments or balance not paid to the practice by the insurance company.

Signature:_____ Date:_____

Medical History Questionnaire

Name: _____ Date of Birth: _____ Today's Date: _____

Primary Care Provider: _____ Optometrist: _____

Please list all eye drops (including non-prescription or over the counter drops) that you currently use:

Medication Name and Strength	**Which Eye?**	**Frequency**
	Right Left Both	
	Right Left Both	
	Right Left Both	
	Right Left Both	
	Right Left Both	
	Right Left Both	

Do you wear contacts or glasses? Yes No **How many years have you worn them?** _____

What kind of contact lenses do you wear? Soft Hard

If not a current contact lens wearer, when did you stop? _____

Have you had any eye surgery, laser treatment, or any other ocular procedure? Yes No

If yes, what, when, and where was it performed? _____

_____

List any other surgeries you have had, including the date of surgery: _____

_____

_____

List all injuries to the head or eye area, including date: _____

Weight: _____ **Height:** _____

Are you Pregnant? Yes No NA **Are you Breastfeeding?** Yes No NA

If under the age of 55, when was your last period? _____

Any history of falls? Yes No

Do you use tobacco products? Current Former Never **If current, how much?** _____

Do you use alcohol? Yes No **If yes, how much and how often?** _____

Do you use recreational drugs? Yes No

Have you had a flu shot this season? Yes No

Have you had a pneumonia vaccination? Yes No

Do you have a history of any of the following:

Methicillin-resistant staphylococcus aureus (MRSA)? Yes No If yes, last active _____

Clostridium difficile (C-Diff)? Yes No If yes, last active _____

Shingles? Yes No If yes, last active _____

Problems with anesthesia? Yes No If yes, please describe_____

_____

Have you been diagnosed with any of the following ocular conditions?

_____ Cataracts	Right Eye ____	Left Eye ____
_____ Glaucoma	Right Eye ____	Left Eye ____
_____ Macular Degeneration	Right Eye ____	Left Eye ____
_____ Retinal Tear	Right Eye ____	Left Eye ____
_____ Retinal Detachment	Right Eye ____	Left Eye ____

Do you have a family history of any of the following:

_____ Glaucoma	Family Member _____
_____ Macular Degeneration	Family Member _____
_____ Blindness or Low Vision	Family Member _____
_____ Diabetes	Family Member _____
_____ Diabetic Eye Disease	Family Member _____
_____ Crossed Eyes	Family Member _____
_____ Retinal Issues/Detachment	Family Member _____
_____ Other Ocular Problems	Family Member _____

Do you currently, or have you ever had any of the following:

Sleep Apnea or CPAP	☐Yes ☐ No	Artificial Heart Valve	☐Yes ☐ No
COPD or Emphysema	☐Yes ☐ No	Atrial Fibrillation	☐Yes ☐ No
Asthma	☐Yes ☐ No	Heart Attack	☐Yes ☐ No
Pulmonary Embolism	☐Yes ☐ No	Pacemaker	☐Yes ☐ No
Supplemental Oxygen	☐Yes ☐ No	Angina (Chest Pain)	☐Yes ☐ No
Congestive Heart Failure	☐Yes ☐ No	Lung Disease	☐Yes ☐ No
Heart Disease	☐Yes ☐ No	High Blood Pressure	☐Yes ☐ No
Cardiac Arrhythmia	☐Yes ☐ No	High Cholesterol	☐Yes ☐ No
Stroke	☐Yes ☐ No	Seizures	☐Yes ☐ No
Arthritis	☐Yes ☐ No	Tremors	☐Yes ☐ No
Paralysis	☐Yes ☐ No	Ulcers	☐Yes ☐ No
Thyroid Disorders	☐Yes ☐ No	BPH (enlarged Prostate)	☐Yes ☐ No
Kidney Disease	☐Yes ☐ No	Cancer	☐Yes ☐ No
Hepatitis	☐Yes ☐ No	Diabetes	☐Yes ☐ No
Dementia	☐Yes ☐ No	If so, what type?	____**I** ____**II**
Dialysis	☐Yes ☐ No	Do you use insulin?	☐Yes ☐ No

Medications:

Are you allergic to any medications that you know of? Yes No If yes, please list below:

Medication	Reaction

Have you ever taken Flomax (Tamsulosin)- ____ Yes ____ No

Please list all medications you are currently taking, including over the counter vitamins and supplements. If more space is needed, use the back of this page.

Name of Medication	Strength	Dosage Taken	Route	Frequency

Additional Information: If you have any additional health history information you would like our doctors to know about, please list it below:

_____

_____

_____

_____

Medical History Reviewed and Updated:

Changes: Y N Signature: _____ Tech Initials: _____ Date: _____

Changes: Y N Signature: _____ Tech Initials: _____ Date: _____

Changes: Y N Signature: _____ Tech Initials: _____ Date: _____

ICON EYECARE
GRAND JUNCTION

Pre Surgical Cataract Patient Questionnaire

Patient Name: _____
Date: _____
Chart Number: _____
Eye Being Evaluated: □Right Eye □Left Eye

VISUAL FUNCTIONING

Do you have difficulty, even with glasses, with the following activities?

		YES	NO
1)	Reading small print, such as labels on medicine bottles, telephone books or food labels?	□	□
2)	Reading a newspaper or book?	□	□
3)	Reading a large-print book or large-print newspaper?	□	□
4)	Recognizing people when they are close to you?	□	□
5)	Seeing steps, stairs or curbs?	□	□
6)	Reading traffic signs, street signs or store signs?	□	□
7)	Doing fine handwork like sewing, knitting, crocheting or carpentry?	□	□
8)	Writing checks or filling out forms?	□	□
9)	Playing games such as bingo, dominoes or card games?	□	□
10)	Taking part in sports like bowling, handball, tennis or golf?	□	□
11)	Cooking?	□	□
12)	Watching television?	□	□

SYMPTOMS

Have you been bothered by the following?

		YES	NO
1)	Poor night vision?	□	□
2)	Seeing rings or halos around light?	□	□
3)	Glare caused by headlights or bright sunlight?	□	□

Patient Name: _____

Eye Being Evaluated:
□ Right Eye □Left Eye

SYMPTOMS

Have you been bothered by the following

	YES	NO
4) Hazy and/or blurry vision?	□	□
5) Seeing well in poor or dim light?	□	□
6) Poor color vision?	□	□
7) Double vision from one eye?	□	□

DRIVING

1) Have you ever driven a car? □ YES (Continue to Question 2) □ No (Stop Here)

2) Do you currently drive a car? □ YES (Continue to Question 3) □ No (Stop Here)

3) How much difficulty do you have driving during the day because of your vision?

□ No difficulty □ Moderate amount of difficulty
□ Little Difficulty □ Great deal of difficulty

4) How much difficulty do you have driving during at night because of your vision?
□ No difficulty □ Moderate amount of difficulty
□ Little Difficulty □ Great deal of difficulty

5) When did you stop driving?
□ Less than 6 months ago □ 6-12 months ago □ More than 1 year ago

Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses won't improve your vision anymore and of the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now?

□ YES □ NO

Patient Signature: _____ Date: _____

Print Name: _____