Heartland Eye Consultants
Adult Patient Demographics

Last Name: _____ First Name: _____ M.I. _____

Street Address: _____ Apt #_____ Gender: ☐ M ☐ F Date of Birth: _____/_____/_____

City: _____ State: _____ Zip Code: _____ Soc. Sec. No. _____-_____-_____

Cell: (_____) _____ Home: (_____) _____ Work: (_____)_____

Please provide your email address for appointment purposes only: **Email:**_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Other_____ ☐ I decline.

Race: ☐American Indian or Alaska Native ☐Asian ☐African-American ☐Pacific Islander ☐White ☐Other Race ☐ I decline

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other_____ ☐ I decline to answer this question.

Special Needs: ☐ Hearing Impaired ☐ Wheelchair ☐ Translator ☐ None ☐ Other_____

Occupation: _____ Employer: _____

Employer's Address: _____ City, State, Zip: _____

Is this visit a result of an accident or illness *that occurred at work*? ☐ Yes ☐ No

Were you referred to our office by a doctor or doctor's office? ☐Yes ☐No If yes, who? _____

Who performed your last eye exam? _____ Date: _____/_____/_____

Family Physician: _____ Approx Location: _____

Emergency Contact: _____ Relationship: _____ Phone: _____
(Not living in household) (Area Code)

If the patient is married, please complete spouse information:

Spouse's Last Name:_____First Name:_____ M.I.____ Birthdate: _____/_____/_____

Cell Phone: _____ Home Phone:_____ Work Phone: _____EXT_____

SSN:_____ Employer: _____ Occupation_____Title: _____

Employer's Address:_____ City_____ State_____Zip_____

The person requesting services is the responsible party.

We will file major medical insurance coverage for you if you provide us with a copy of your current card.
For patients without insurance coverage, you will be responsible for payment. Please indicate your preferred method of payment:
Cash Check Credit Card (Mastercard or Visa. We do not accept Discover or American Express)

Photo Release: I hereby grant Heartland Eye Consultants, L.L.C. and Developmental Vision Associates, P.C. permission to have my photograph taken for patient information. This does not allow them to use my likeness in photographs and/or video in any of its publications or media.

AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY AND ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILITY FOR PAYMENT

I hereby assign all medical benefits (to which I am entitled) to the doctor caring for me. This includes major medical benefits, Medicare, Medicaid, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance and that 15% APR will be applied to all accounts not paid within 30 days. I hereby authorize the holder of my medical and patient registration records to release any information need to process my insurance claims. I understand that I am the guarantor of this account.

$15 Fee may incur if a copy of my medical records are requested in writing and will be provided whomever I designate.
$25 Fee will incur for all returned checks.
$50 A deposit will be required to schedule an appointment if you fail to keep an appointment or if you repeatedly reschedule your appointment with less than a 48 hour notice. This deposit will be credited to your bill if you keep your appointment as scheduled. However, you will forfeit the deposit if you No Show or reschedule again with less than a 48 hour notice.

****I authorize communication of my medical records to be released to: _____**
Authorized Signature: _____Date of Signature: _____
PLEASE INITIAL _____ You have read and are aware of the HIPAA privacy policy and agree with its provisions.

ADULT VISION HISTORY QUESTIONNAIRE

Please fill out this questionnaire carefully. Please bring it with you to your appointment. Thank you!

Full Name_____DOB____/____/_____Age _____ ☐ Male ☐ Female

Occupation: _____

PRESENT SITUATION

Why do you believe you need a visual evaluation? _____

_____

How long has this problem/difficulty existed? _____

****

STRABISMUS: Do you have an eye that turns in, out, up or down? If no, skip this section

At what age was it first noticed *or suspected* that an eye was turning? _____
Was there trauma/disease that preceded or accompanied the onset of the eye turn? ☐ Yes ☐ No
If yes, please explain: _____
Did the eye begin turning ☐ suddenly? ☐ gradually?
Does the eye turn ☐ in? ☐ out? ☐ up? ☐ down? (Check all that apply)
Is the eye turn getting ☐ worse? ☐better? or is there ☐ no change?
Is it always the same eye that turns? ☐ Yes ☐ No
If yes, which eye? ☐ Right ☐ Left
Is the eye turn always present? ☐Yes ☐ No
If no, under what conditions is it present? (I.e. when tired, ill, etc.) _____
Does the eye always turn the same amount? ☐ Yes ☐ No
If no, explain: _____
Do you notice if the eye turns more when you look:
at objects up close? ☐Yes ☐ No
at objects in the distance? ☐Yes ☐ No
to your left? ☐ Yes ☐ No
to your right? ☐Yes ☐ No
up? ☐Yes ☐ No
down? ☐Yes ☐ No
Does one pupil ever appear to be larger than the other? Yes ☐ No ☐
Do you ever notice one or both eyes shaking rapidly? Yes ☐ No ☐

****

BRAIN INJURY: Have you ever experienced any type of brain injury? If no, skip this section

Type/cause of injury? _____
When did the injury occur? _____
Did you lose consciousness? ☐ Yes ☐ No
If yes, how long: _____
Were you hospitalized? ☐ Yes ☐ No
If yes, how long: _____
Have you completed any types of therapy? ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy
☐ Other: _____
Are your symptoms ☐ worse? ☐ better? or is there ☐ no change?

Since the injury do you experience any of the following?

	Yes	No	If yes, when?
Vision loss	☐	☐	
Photophobia (sensitivity to lights or glare)	☐	☐	
Bothered by fluorescent lights	☐	☐	
Phonophobia (sensitivity to sound)	☐	☐	
Dizziness/Imbalance/Vertigo	☐	☐	
Miss-judge where objects are	☐	☐	
Symptoms exacerbated or induced by visually busy environments or motion	☐	☐	
Avoid crowds/can't tolerate "visually-busy" environments	☐	☐	
Bothered by movement in side vision	☐	☐	
Difficulty making decisions/processing	☐	☐	
Slowed thinking	☐	☐	
Misplace/lose things	☐	☐	
Difficulty with word/name retrieval	☐	☐	
Forgetfulness	☐	☐	
Confusion	☐	☐	
Irritability	☐	☐	
Feeling anxious or tense	☐	☐	
Feeling depressed or sad	☐	☐	
More easily frustrated	☐	☐	
Numbness or Tingling	☐	☐	
Difficulty sleeping or disrupted sleep patterns	☐	☐	
Walk or bump into things on the side	☐	☐	
Forget food on one side of plate	☐	☐	
Forget to shave or put cosmetics on one of the face	☐	☐	

****

Do you experience any of the following?

	Yes	No	If yes, when?
Headaches	☐	☐	
Double vision	☐	☐	
Blurred vision at distance/near	☐	☐	which?
Red or itchy eyes	☐	☐	
Burning/dry eyes	☐	☐	
Watery eyes	☐	☐	
Strained or tired eyes	☐	☐	
Nausea associate with visual tasks	☐	☐	
Tilt head	☐	☐	
Squinting, covering or closing one eye	☐	☐	
Loss of interest or short attention span for any close work	☐	☐	
Difficulty sustaining reading / writing	☐	☐	
General fatigue worse than family/friends	☐	☐	

	Yes	No	If yes, when?
Lose place on line when reading	☐	☐	
Skip lines when reading	☐	☐	
Repetition/Omission of words when reading	☐	☐	
Falling asleep when reading	☐	☐	
Motion sickness / car sickness	☐	☐	
General difficulty with comprehension	☐	☐	
Comprehension decreases over time	☐	☐	
Letters or words appear to move or float around when reading	☐	☐	
Difficulty aligning columns of numbers	☐	☐	
Difficulty hitting or judging moving targets in sports	☐	☐	
Difficulty driving	☐	☐	
Inconsistent performance in work or sports	☐	☐	
Poor general coordination / clumsiness	☐	☐	
Poor fine motor coordination	☐	☐	
Difficulties with short/long term memory	☐	☐	

Comments on any items above: _____

Do you believe your vision hampers your daily activities or limits your potential in any way? Yes ☐ No ☐

If yes, please explain: _____

COMPUTERS

Do you use a computer in your work, school, or leisure time activities? Yes ☐ No ☐
How many hours do you spend in front of a computer screen each day? _____
How do your eyes feel after working at the computer? _____
Do you wear "computer glasses" for computer work? Yes ☐ No ☐
Please describe any problems you have with computer work:

HOBBIES/SPORTS

Are you seriously involved with athletics? Yes ☐ No ☐ If no, skip to the next section.
Do you believe you are achieving up to your potential in sports/athletics? Yes ☐ No ☐

PERSONAL AND FAMILY MEDICAL HISTORY

Current medications used including vitamins and supplements: _____

For what condition(s)? _____

Are you allergic to any medications? Yes ☐ No ☐

If yes, please list: _____

Current state of health (explain): _____

Are there any problems with any of the following? (Please check if there is a history)

	You	Family	Who?		You	Family	Who?
Diabetes	___	___	_____	High Blood Pressure	___	___	_____
Glaucoma	___	___	_____	Cataracts	___	___	_____
Thyroid Disease	___	___	_____	Heart Disease	___	___	_____
Blood Disorder	___	___	_____	Hormone Disorder	___	___	_____
Multiple Sclerosis	___	___	_____	Allergies	___	___	_____
Breathing	___	___	_____	Stomach/Intestines	___	___	_____
Ears/Nose/Mouth	___	___	_____	Blindness	___	___	_____
Amblyopia	___	___	_____	Strabismus	___	___	_____
Brain Tumor	___	___	_____	Cancer	___	___	_____

If there is any other information that you believe would be helpful to the doctor for your evaluation/treatment please explain: _____

_____

_____ _____

Signature Date

Please give this form to the Patient Care Coordinator when you are finished. Thank you!