DESAI VISION

Dr. Deval Desai, OD PLLC

HISTORY QUESTIONNAIRE

Patient Information: (Please Print)

Patient Name _____ MI _____ Today's Date _____/_____/_____

Date of Birth _____/_____/_____ Sex ☐ M ☐ F

Mailing Address: _____ Physical Address

_____

City _____ State _____ Zip _____

Home Phone _____ Work _____

E-mail Address _____

Occupation _____ Employer _____

Insurance (Medical) ☐ Yes ☐ No Provider? _____

Insurance (Vision) ☐ Yes ☐ No Provider? _____

Do you have Medicare? ☐ Yes ☐ No

MEDICAL HISTORY

Primary Care Physician: _____ Last eye exam? _____ By Whom? _____

Do you have any allergies to medication? ☐ Yes ☐ No If yes, explain: _____

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

_____

_____

List and major injuries, surgeries, and/or hospitalizations you have had _____

_____

Circle any of the following you have had: crossed eye, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections or eye injuries

Are you pregnant and/or nursing? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how are you lenses? _____

Do you wear contacts? ☐ Yes ☐ No If yes, how are you lenses? _____

Contact lens type: ☐Rigid ☐Soft ☐ Extended Wear ☐Other Are they comfortable? ☐ Yes ☐ No

Contact lens disinfectant type? _____

SOCIAL HISTORY

All of this information is kept confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No

If yes, please explain

_____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long_____

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long_____

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long_____

Do you work on a computer? ☐ Yes ☐ No

Do you work under florescent lighting? ☐ Yes ☐ No

Do you have trouble with glare? ☐ Yes ☐ No

Do you participate in sports that require eye protection? ☐ Yes ☐ No

Would you like to try contacts? ☐ Yes ☐ No

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

FAMILY HISTORY

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

		Relationship
Blindness	☐ Yes ☐ No ☐ ?	_____
Cataract	☐ Yes ☐ No ☐ ?	_____
Cross Eyes	☐ Yes ☐ No ☐ ?	_____
Glaucoma	☐ Yes ☐ No ☐ ?	_____
Macular Degeneration	☐ Yes ☐ No ☐ ?	_____
Retinal Detachment/Disease	☐ Yes ☐ No ☐ ?	_____
Arthritis	☐ Yes ☐ No ☐ ?	_____
Cancer	☐ Yes ☐ No ☐ ?	_____
Diabetes	☐ Yes ☐ No ☐ ?	_____
Heart Disease	☐ Yes ☐ No ☐ ?	_____
High Blood Pressure	☐ Yes ☐ No ☐ ?	_____
Kidney Disease	☐ Yes ☐ No ☐ ?	_____
Lupus	☐ Yes ☐ No ☐ ?	_____
Thyroid Disease	☐ Yes ☐ No ☐ ?	_____
Other	☐ Yes ☐ No ☐ ?	_____

REVIEW OF SYSTEMS

Do you currently, or have you ever had, any problems in the following areas:

Fever, weight loss/gain	☐ Yes ☐ No ☐ ?	Glare/Light Sensitivity	☐ Yes ☐ No ☐ ?	High Blood Pressure	☐ Yes ☐ No ☐ ?
Skin	☐ Yes ☐ No ☐ ?	Eye Pain or Soreness	☐ Yes ☐ No ☐ ?	Vascular Disease	☐ Yes ☐ No ☐ ?
Headaches	☐ Yes ☐ No ☐ ?	Chronic Infection of Eye or Lid	☐ Yes ☐ No ☐ ?	Chronic Diarrhea	☐ Yes ☐ No ☐ ?
Migraines	☐ Yes ☐ No ☐ ?	Stys or Chalazion	☐ Yes ☐ No ☐ ?	Chronic Constipation	☐ Yes ☐ No ☐ ?
Seizures	☐ Yes ☐ No ☐ ?	Flashes/Floaters in Vision	☐ Yes ☐ No ☐ ?	Gential/Kidney/Bladder	☐ Yes ☐ No ☐ ?
Loss of Vision	☐ Yes ☐ No ☐ ?	Tired Eye	☐ Yes ☐ No ☐ ?	Rheumatoid Arthritis	☐ Yes ☐ No ☐ ?
Blurred Vision	☐ Yes ☐ No ☐ ?	Thyroid/ Other Glands	☐ Yes ☐ No ☐ ?	Muscle Pain	☐ Yes ☐ No ☐ ?
Distorted Vision/Halos	☐ Yes ☐ No ☐ ?	Allergies/Hay Fever	☐ Yes ☐ No ☐ ?	Joint Pain	☐ Yes ☐ No ☐ ?
Loss of Side Vision	☐ Yes ☐ No ☐ ?	Sinus Congestion	☐ Yes ☐ No ☐ ?	Anemia	☐ Yes ☐ No ☐ ?
Double Vision	☐ Yes ☐ No ☐ ?	Runny Nose	☐ Yes ☐ No ☐ ?	Bleeding	☐ Yes ☐ No ☐ ?
Dryness	☐ Yes ☐ No ☐ ?	Post-Nasal Drip	☐ Yes ☐ No ☐ ?	Allergic/Immunologic Psychiatric	☐ Yes ☐ No ☐ ?
Mucous Discharge	☐ Yes ☐ No ☐ ?	Chronic Cough	☐ Yes ☐ No ☐ ?	If you answered yes to any of the above or have a condition not listed	
Redness	☐ Yes ☐ No ☐ ?	Dry Throat/Mouth	☐ Yes ☐ No ☐ ?	please explain and list medications: _____	
Sandy or Gritty Feeling	☐ Yes ☐ No ☐ ?	Asthma	☐ Yes ☐ No ☐ ?	_____	
Itching	☐ Yes ☐ No ☐ ?	Chronic Bronchitis	☐ Yes ☐ No ☐ ?	_____	
Burning	☐ Yes ☐ No ☐ ?	Emphysema	☐ Yes ☐ No ☐ ?	_____	
Foreign Body Sensation	☐ Yes ☐ No ☐ ?	Diabetes	☐ Yes ☐ No ☐ ?	_____	
Excess Tearing/Watering	☐ Yes ☐ No ☐ ?	Heart Pain	☐ Yes ☐ No ☐ ?	_____	

Informed Consent for Refusal for Dilated Fundus Exam

Dilation involves instilling eye drops for the purpose of enlarging the pupils of the eyes to better check the health of the inside of the eyes.

The pupils are simply an entry way/opening to the inside of the eye. Looking through and undiluted pupil is similar to looking into a room through a keyhole in the door; the doctor may see only about 20% to 50% of what is inside. However, looking through a dilated pupil is like looking into a room thought an open door; the doctor gets a complete view of inside of the eye.

A dilated fundus exam is recommended at the time of your annual examination. Diabetics need to have an annual dilated examination. We will send a letter to the primary care provider of these patients summarizing the results.

Benefits

Dilation allows the doctor to get a better view of the peripheral retina for disease. It is highly recommended if you or your family has a history of high blood pressure, diabetes, past retinal problems (i.e., retinal detachment), or extreme nearsightedness. It is also recommended if you have experienced sudden cloudiness of vision, especially in one eye, "curtain or veil-like" obstruction of vision, a sudden onset of many "floaters" or flashing lights off the side of you vision.

Risks

- Some blurring of vison and glare because of enlarged pupils for about 2 (but up to 6) hours. You should not operate heavy equipment or drive and automobile unless are comfortable with your vision.
- Difficulty with near reading for 1 to 2 hours. The focusing ability is impaired and may cause a slight headache if you try to read.

Please Check One:

_____ I understand the above and consent to have dilation done.

_____ I understand the above and decline dilation at this time. I understand the potential for partial of total loss of vision my exist and, without dilation, my go undetected.

I have read and understand the above.

Signature: _____ Date: _____

(Parent or Guardian if patient is under 18 years of age)

Patient Acknowledgment

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice mat change. If we change our notice, you may obtain a revised copy of contacting us.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound to our agreement.

By signing this form, you consent to our use and disclosure of protected health information, about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosure in reliance in your prior consent.

Patient's name (print):_____

Patient's Signature: _____ Date: _____

(Parent or Guardian of patient is under 18 years of age)

Acknowledgment of Financial Responsibility

I authorize Dr. Deval I. Desai O.D. or my insurance company to release any information needed to process my claims. I understand that I am financially responsible for any co pay, co-insurance, deductible, and other non-covered services or materials the day services are rendered. I also understand I am financially responsible for any balance after my claim has been processed.

Patient's Signature: _____ Date:_____

(Parent or Guardian of patient is under 18 years of age)