



LOW VISION INSTITUTE

NEW PATIENT INFORMATION

CONTACT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: Male or Female (circle one)

Marital Status: Single Married Divorced Widowed Other

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell Phone: _____

Email Address: _____

Alternate Contact:

Name: _____ Relationship: _____

Phone Number: _____

Is this person also your emergency contact?

Yes

No

If no, please provide information for your **Emergency Contact:**

Name: _____ Relationship: _____

Phone Number: _____

Communication Preferences

I authorize Low Vision Institute of Texas to communicate with me via (select all that apply):

- Text Message
- Email Address
- Phone Call

I authorize Low Vision Institute of Texas to leave the following types of messages for me at my approved method(s) of contact:

- Detailed Messages
- Provide Call Back Information Only (no medical information)
- Do Not Leave Messages

GENERAL INFORMATION

What eye condition(s) have you been diagnosed with?

- Macular Degeneration
- Glaucoma
- Diabetic Retinopathy
- Retinitis Pigmentosa
- Stroke-Related Vision Loss
- Other: _____

Are you under the care of an optometrist and/or ophthalmologist for your eye condition(s)? If so, please provide your doctor's information:

Optometrist Name: _____ Phone: _____

Address/Location: _____

Ophthalmologist Name: _____ Phone: _____

Address/Location: _____

Pharmacy Information

Name: _____ Phone Number: _____

Address/Location: _____

PATIENT OCULAR HISTORY

Do you currently have, or do you have a history of the following:

- | | |
|---|---|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glare Sensitivity |
| <input type="checkbox"/> Crossed Eye/Lazy Eye | <input type="checkbox"/> Ocular Headache/Migraine |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Ocular Allergies |
| <input type="checkbox"/> Dry Eye | <input type="checkbox"/> LASIK/PRK |
| <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Ocular Trauma |
| <input type="checkbox"/> Foreign Body Sensation | <input type="checkbox"/> Retinal Detachment |

PATIENT MEDICAL HISTORY

Do you currently have, or do you have a history of the following:

- Diabetes If yes, what year were you diagnosed? _____
If yes, what was your most Recent A1c? _____

- | | |
|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Connective Tissue Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> None |

Are you taking any **eye** medications? If so, please list: _____

Are you taking other medications? If so, please list: _____

Do you have any drug allergies? Yes No

If so, please list: _____

Are you pregnant? Yes No N/A

Are you nursing? Yes No N/A

Please list any **eye** surgeries (cataract/glaucoma, etc.) and approximate dates, if known: _____

Please list any major surgeries/hospitalizations and approximate dates, if known: _____

FAMILY MEDICAL HISTORY

Does anyone in your family have a history of:

Diabetes

High Blood Pressure

High Cholesterol

Other: _____

Thyroid Disease

Cardiovascular Disease

Cancer

FAMILY OCULAR HISTORY

Does anyone in your family have a history of:

Glaucoma

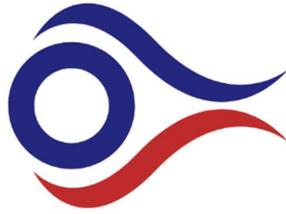
Cataracts

Macular Degeneration

Retinal Detachment

Crossed Eye/Lazy Eye

Blindness



LOW VISION INSTITUTE
LOW VISION QUESTIONNAIRE

Which eye do you feel that you see better out of?

- Right Left Same N/A

What are the visual tasks that you would like help with? Please check all that apply.

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Computer | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Writing | <input type="checkbox"/> Work Tasks | <input type="checkbox"/> Seeing Faces |
| <input type="checkbox"/> TV | <input type="checkbox"/> Glare Control | <input type="checkbox"/> Household Chores |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Personal Care/
Grooming | <input type="checkbox"/> Hobbies |
| <input type="checkbox"/> Education | | |

Other (please describe): _____ Do

you have any additional challenges, such as problems with mobility, hearing, dexterity, etc.?

- Yes No

If yes, please explain: _____

Please describe your current employment status:

- Full-Time Part-Time Unemployed Student Retired

Other comments or concerns: _____

Acknowledgment of Notice of Privacy Practices

Low Vision Institute of Texas, PLLC
4020 W Plano Pkwy Plano, TX 75093
Phone: 469-999-2747
Fax: 469-606-0925
Email: hello@lowvisiontx.com

The law requires that Low Vision Institute of Texas, PLLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that I was given the opportunity to read, have read, or have explained to me Low Vision Institute of Texas, PLLC Notice of Privacy Practice prior to any services rendered.

I authorize Low Vision Institute of Texas, PLLC to release my personal health information to the following individuals:

Person 1 Name: _____

Phone: _____ Relationship: _____

Person 2 Name: _____

Phone: _____ Relationship: _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Name: _____

Patient Signature: _____ Today's Date: _____

If you are signing as a personal representative of the patient, please sign below.

Personal Representative Name: _____

Personal Representative Signature: _____

Relationship to Patient: _____ Today's Date: _____