LANG FAMILY EYE CARE

# Patient Health Questionnaire

Date: ____/____/_____

FULL NAME:_____ DATE OF BIRTH: _____/_____/_____

ADDRESS: _____

PREFERRED PHONE #:_____ HOME OR CELL? EMAIL ADDRESS:_____

SOCIAL SECURITY #:_____ LAST EYE EXAM: _____

MEDICAL DOCTOR:_____ LAST MEDICAL EXAM:_____/_____/_____

OCCUPATION:_____ EMPLOYER:_____

MEDICAL INSURANCE (NAME & ID#):_____

VISION INSURANCE (NAME & ID#):_____

**POLICY HOLDER NAME (IF DIFFERENT):**_____

**POLICY HOLDER DOB:** _____/_____/_____ **RELATIONSHIP TO PATIENT:**_____

Who may we thank for referring you to our office: _____

## OCULAR HISTORY

Do you wear glasses? ☐No ☐Yes If yes, how old is your current pair of lenses? _____

Do you wear contact lenses? ☐No ☐Yes If yes, what brand? _____

How often do you wear them?_____ How frequently do you replace them? _____

Have you had refractive surgery? _____ If yes, Date _____ Type _____

Are you having any vision problems? _____ If yes, please explain: _____

_____

Are you currently experiencing any of the following problems with your eyes? **Check the box if "Yes."**

☐Blurred Vision
☐Loss of Vision
☐Distorted Vision
☐Double Vision
☐Eye Strain/Fatigue
☐Headaches
☐Flashes / Floaters
☐Halos / Glare
☐Dryness
☐Foreign Body Sensation
☐Burning
☐Itching
☐Redness
☐Excess Tearing / Watering
☐Eye Pain
☐Mucous Discharge
☐Swelling of the Eyelids
☐Styes

Have you been diagnosed with any of the following ocular problems? **Check the box if "Yes."**

☐Cataracts
☐Crossed Eyes/Strabismus
☐Dry Eye
☐Eye Injury
☐Glaucoma
☐Lazy Eye/Amblyopia
☐Macular Degeneration
☐Retinal Detachment
☐Other_____

----------Office Use Only----------

Color ___/___ ☐VF ☐Dilating or ☐Complete ☐Follow up appt in _____ days
Depth ___/___ ☐FP Fitting: SPH TOR MF ☐Follow up call in _____ days

## MEDICAL HISTORY

List any medications you are currently taking (including over the counter and supplements): _____

_____

_____

Are you allergic to any medications? ☐No ☐Yes If yes, which ones: _____

_____

**REVIEW OF SYSTEMS** Please check box if "yes" to any conditions you have or have had in the past

**ALLERGIC / IMMUNOLOGIC**
- ☐ Allergy / Hay Fever

**CARDIOVASCULAR / CARDIAC**
- ☐ Vascular Disease
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol

**CONSTITUTIONAL**
- ☐ Developmental Disabilities
- ☐ Fatigue Syndrome

**EARS, NOSE, MOUTH, THROAT**
- ☐ Sinus Congestion
- ☐ Dry Throat / Mouth

**ENDOCRINE**
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Thyroid Disease

**GASTROINTESTINAL**
- ☐ Colitis/Crohn's Disease
- ☐ Ulcers
- ☐ Acid Reflux

**GENITOURINARY**
- ☐ Kidney Disease
- ☐ Ovarian / Uterine Cancer
- ☐ Prostate Cancer

**HEMATOLOGIC / LYMPHATIC**
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Breast Cancer

**INTEGUMENTARY (Skin)**
- ☐ Cancer
- ☐ Psoriasis/Eczema

**MUSCULOSKELETAL**
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Gout

**NEUROLOGICAL**
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Stroke

**PSYCHIATRIC**
- ☐ Anxiety
- ☐ Depression
- ☐ ADD/ADHD
- ☐ Mood Disorder

**RESPIRATORY**
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Sleep Apnea

If you checked any of the above boxes or have a condition not listed, please explain further: _____

_____

_____

Are you pregnant or nursing? ☐ No ☐ Yes

## FAMILY HISTORY Please check the box if "yes" (include parents, siblings, grandparents, & children)

- ☐ Glaucoma
- ☐ Cataract
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Blindness
- ☐ Crossed Eyes/ Lazy Eye
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Keratoconus

Signature:_____ Date_____/_____/_____

LANG FAMILY
EYE CARE

**HEALTH TESTING NECESSARY FOR PATIENT CARE**

Your vision insurance is defined as a minimal or basic eye examination. There are two vital health tests that we recommend in order to provide preventive eye health evaluations and preserve your sight by early detection of systemic (body) disease and eye disease.

**RETINAL PHOTOGRAPHY**- taking yearly colored photographs of the inside of the eyes is much like a dentist x-raying your mouth annually. The retinal photos document the internal health of your eyes and allow for accurate yearly comparisons. Retinal photography establishes baseline health information, which will allow earlier diagnosis in the event your eye health changes in the future. It is strongly recommended for all patients and certainly important for anyone with a family history of glaucoma, diabetes, macular degeneration, and any other sight threatening diseases. These photos enable the doctor to detect early eye health changes so that early treatment may be instituted to preserve your sight.

**VISUAL FIELDS**- is one of the most state of the art medical eye tests available. The findings from this test enable doctors to determine if there is any retinal disease and if there is any disease process behind the eye all the way to the back of the brain. The visual field instrument tests peripheral vision paramount in driving and work related tasks. This test should be administered every year since the conditions looked for can develop in anyone at any time.

**These screening tests are not covered under your vision insurance. The fee is due today.**

*Note: A professional courtesy (savings) of $15.00 when all tests are administered.*

_____ YES- I choose to have both preventive health tests performed at $30.00.
I understand the fees are due today.

_____ YES- I choose to have only: (check your choices)
_____ RETINAL PHOTOGRAPHY ($25.00)
_____ VISUAL FIELDS ($20.00)

_____ NO- I choose to neglect the health tests and I understand the medical risks involved.

*If any questions or concerns regarding these procedures, please inquire with Dr(s). Lang.*

_____ Date_____
Patient Signature (Parent or legal guardian under 18)

_____
Printed Name of Patient

----------Office Use Only----------

Color ___/___ ☐VF ☐Dilating or ☐Complete ☐Follow up appt in _____ days

Depth ___/___ ☐FP Fitting: SPH TOR MF ☐Follow up call in _____ days

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EYE CARE

## PAYMENT POLICY

Examination fee and copayments for materials are due at the time of service and must be paid in full prior to ordering. If you have insurance coverage for these services or materials, we will submit claims for you. However, we are not liable for collecting your claim. After 30 days, we will expect payment in full if your insurance company has not paid. Returned NSF checks will be charged a service fee of $25.00. Spectacle lenses and specialty contact lenses are custom made and tailored medical devices and therefore are non-refundable. We will happily troubleshoot any issues that may arise, and exchange or credit, as needed, in the first **30** days after the order has been dispensed.

I Hereby authorize my insurance carrier to make a payment directly to Lang Family Eye Care for any and all services rendered to me by Lang Family Eye Care. I understand that I am financially responsible for all charges whether or not covered by insurance.

**I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.**

_____ Date_____
Patient Signature (Parent or legal guardian under 18)

_____
Printed Name of Patient

## HIPAA PRVIACY POLICY ACKNOWLEDGEMENT

I, _____, hereby acknowledge that I am aware of the Privacy Policy and Practices for Lang Family Eye Care that explains how my health information may be used and disclosed and how I can get access to that information. I understand that I am able to request a copy of this notice, or discuss any questions I may have regarding the privacy notice with my provider.

_____ Date_____
Patient Signature (Parent or legal guardian under 18)

_____
Printed Name of Patient

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# CONTACT LENS POLICY

The purpose of your annual contact lens exam is to ensure the fit, comfort, and clarity of your contact lenses. The contact lens exam is separate from the routine vision exam, which is the determination of your eyeglass prescription.

Contact lens prescriptions are valid for one year from the date of your exam and cannot be renewed without an annual contact lens examination. If it has been one year or more since your contact lens exam, you will need a new examination to order contact lenses.

**A contact lens fee will be charged to renew your prescription. If your insurance company does not cover this fee in full, then payment or copayment will be required at the time of service. This fee is non- refundable.**

The contact lens evaluation fee will cover the initial evaluation, as well as any follow up care necessary within the following **60 days.** Any follow up care after this time period is subject to a **$40 fee**.

*I have read the above information and understand the contact lens policy. I would like to be evaluated for contact lenses at this time.*

_____ _____

Patient Signature (Parent/Guardian if under 18) Date

_____

Patient Name (If under 18)

FOR PATIENT USE

# Lifestyle Index

FOR OFFICE USE

PT INITIALS _____

DATE _____

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — **whether it's caused by your eyes, posture, stress, etc**. Your responses will help make sure you receive the best care possible.

**How often do you experience any of these symptoms? Fill in applicable circle. For example:** 1 2 3 4 5 (3 selected)

## Headaches

- You get headaches of any severity each week (even just a dull ache counts).
- Your headaches tend to get worse later in the day.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Sometimes | Very Often | Always |
| ○ | ○ | ○ | ○ | ○ |

Additional notes: _____

## Stiffness / pain in neck / shoulders

You experience stiffness/tension in your neck/shoulders when you work at a computer or read (this might even be from your posture).

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Sometimes | Very Often | Always |
| ○ | ○ | ○ | ○ | ○ |

Additional notes: _____

## Discomfort with Computer Use

Your eyes get tired, burn, or get red easily when you work at a computer for long hours.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Sometimes | Very Often | Always |
| ○ | ○ | ○ | ○ | ○ |

**Number of hours per day using a digital device:** _____

## Tired Eyes

Your eyes feel increasingly fatigued/tired as the day goes on.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Sometimes | Very Often | Always |
| ○ | ○ | ○ | ○ | ○ |

Additional notes: _____

## Dry Eye Sensation

Your eyes progressively feel more dry/sandy/gritty while working at the computer or reading.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Sometimes | Very Often | Always |
| ○ | ○ | ○ | ○ | ○ |

Additional notes: _____

## Light Sensitivity

Bright / Strong lights (vehicle headlights, florescent lights etc.) bother you.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Sometimes | Very Often | Always |
| ○ | ○ | ○ | ○ | ○ |

Additional notes: _____

## Dizziness

You experience dizziness, motion sickness, or vertigo.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never | Rarely | Sometimes | Very Often | Always |
| ○ | ○ | ○ | ○ | ○ |

Additional notes: _____

## Additional Notes

Any additional notes you'd like to add: _____

_____