Patient History Questionnaire

Patient's Name:___________________________________ Today's Date:_________________

Reason for appointment:

Eye related condition or Surgeries:

Please list any current eye drops along with the dosage and frequency:

Medical History: (please circle all that apply)

- Allergies: Chronic or seasonal
- Alzheimer's and or Dementia
- Anemia/bleeding disorder
- Arthritis/ Rheumatoid
- Cancer ___________________
- COPD
- Diabetic: Type 1 Type 2 Gestational Last A1C__________
  Primary Care DR._____________ Endocrinologist DR.__________ Last Appt:_________
- Heart Attack
- Heart Condition___________________
- Heart Disease/Vascular disease
- Hepatitis A B C
- Herpes Virus/Cold Sores/Shingles
- High Cholesterol
- HIV/AIDS
- Kidney Disease/Dialysis
- Liver Disease
- Long Term or Current Steroid Use
- Lung Disease/ TB
- Restless Leg Syndrome

- Lupus
- Melanoma
- Meningitis
- Migraine
- Multiple Sclerosis
- Pneumonia
- Pregnant or Nursing
- Psychiatric Disorder
- Recent Chemotherapy Treatment or Current
- Recent Fall
- Radiation
- Seizures
- Sickle Cell
- Sleep Apnea
- Stroke/TIA (Transient Ischemic Attack)
- Sexually Transmitted Infection
- Temporal Arteritis/ Polymyalgia Rheumatic
- Terminal Illness_______________________
- Thyroid Disease
- Sarcoidosis

Medical Surgeries (Please circle all that apply)

- **None ________**
- Amputation
- Angioplasty
- Back surgery
- Blood Transfusion
- CABG/Bypass surgery
- Defibrillator/Pacemaker
- Gastric bypass
- Heart Stent
- Mastectomy
- Thyroidectomy
- Transplant :_______
- Other:_____________________
- Head/body Trauma : *Date*_____________
- Ocular Trauma : *Date*_____________

Review Of Systems (Please circle all that apply with explanation)

Allergy/Immunology:

- None
- Immunosuppressed
- Seasonal/ Drug Allergies

Cardiovascular:

- None
- Chest Pain
- Shortness of Breast
- Irregular heart Palpitations
- High Blood Pressure
- Swelling Of Extremities
- Low or High Heart Rate

Constitutional:

- None
- Intolerance to cold/heat
- Hair loss
- Nervousness
- Fever Chills
- Weight Loss
- Loss of Appetite
- Fatigue
- Feels sick/ weak.

Endocrine:

- None
- Excessive Thirst
- Excessive Urination
- Intolerance of cold/Heat
- Hair Loss
- Unstable blood sugar

Gastrointestinal:

- None
- Abdominal Pain
- Nausea Vomiting Diarrhea
- Bloody Stool
- Stomach Ulcer
- Trouble Swallowing

Genitourinary:

- None
- Urinary problems: ________________
- Kidney Stones

Hematology/Oncology:

- None
- Easy Bruising
- Prolonged Bleeding
- Swollen Lymph Nodes

Head/Ears/Nose/Throat:

- None
- Hearing loss/ Ringing
- Sore Throat or Difficulty Swallowing
- Runny Nose, Congestion or Nose Bleeds
- Dry Mouth
- Pain when you chew
- Earache
- Stiff Neck or Neck Pain

Skin (Integumentary)

- None
- Rash
- Change in Mole
- Skin Sores
- Nail Changes
- Fever Blisters

Musculoskeletal:

- None
- Muscle Aches
- Joint Pain/ Swelling
- Back Pain

Neurologic:

- None
- Weakness, Numbness or Tingling
- Headaches
- Scalp Tenderness
- Dizziness or Vertigo
- Paralysis Of Extremities
- Tremor
- Difficulty walking
- Seizures or Convulsions
- Fainting

Psychiatric:

- None
- ADHD
- Bipolar Disorder
- Depression or Anxiety
- Panic Attack
- Hallucinations/ Schizophrenia

Respiratory:

- None
- Wheezing
- Coughing
- Severe of Frequent Colds
- Difficulty Breathing or Ashma
- Emphysema/ COPD

Social History :

Alcohol status:

Daily Occasional Former Never

Street Drugs:

Daily Occasional Former Never

Smoking Tobacco Usage:

Daily Occasional Former Never

Marital Status:

Living Condition:

Alone Nursing home With Family Other_______________

Do you drive? ________

Family History :

- Retinal Detachment
- Diabetes
- Glaucoma/ Macular Degeneration
- Cancer
- Stroke/ Heart Disease
- Cataracts
- Arthritis Autoimmune Disease
- Kidney Disease
- Thyroid Disease
- Autoimmune Disease

Please list ALL your current medications or provide an up-to-date list:

Name/ Dose/ Frequency/ Route

__________________________ _______________________________

__________________________ _______________________________

__________________________ _______________________________

__________________________ _______________________________

__________________________ _______________________________

__________________________ _______________________________

__________________________ _______________________________

Please list ANY allergies:

_________________________ __________________________

_________________________ __________________________

_________________________ __________________________

We appreciate you taking the time to fill out your information. This information is important in helping Dr. Klaas complete your treatment plan. Thank you!

Patient Information Sheet

[ ]Mr. [ ]Mrs. [ ]Ms. First Name: ___________________MI: ___ Last Name: ___________________

Mailing Address: _______________________ City: ____________________ State: ____ Zip: ______

DOB: __________________ Age: ___________ Sex: _________ Today's Date: __________________

Home Phone: __________________ Work Phone: __________________Cell Phone: _____________

Marital Status: _____________ Social Security Number: ______________________ Race: ________

Language: _________________ Email: ____

Employed: Y or N If yes: Full time Part time Self Retired Military Occupation: _____________

*****PRIMARY INSURANCE INFORMATION*****

Insurance Company: _____________________ ID# ___________________Group# __________

Policyholder's Full Name: ______________________ DOB: __________ SSN:_______________

Relationship to patient: Self ___ Spouse ___ Child ___

SECONDARY INSURANCE INFORMATION

Insurance Company: _____________________ ID# ___________________Group# __________

Policyholder's Full Name: ______________________ DOB: __________ SSN:_______________

Relationship to patient: Self ___ Spouse ___ Child ___

Preferred Pharmacy: ____

Emergency Contact Name: _________________________________ Relationship: _______________

Phone#: __________________________ Address: ____

Referring Physician: _______________________ Primary Care Physician: ______________________

I hereby authorize the physician and staff of Retina Specialists of Indiana to perform procedures necessary to assess and diagnose my condition properly and such treatments as may be prescribed by the physician during any and all visits to RSI, I understand that I am financially responsible for ALL charges arising from services rendered to me by RSI. SIGNATURE: _________________________________ Date: ______________________________

HIPPA Authorization For Use Or Disclosure Of Health Information

Date:

I. THE PATIENT. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name:
Date of Birth:
Patient's MRN:

II. AUTHORIZATION. I authorize Dr. Klaas and staff to use or disclose the following:

By signing this acknowledgment of Receipt of Notice of Privacy Practices, I acknowledge and agree that I have read and can receive a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that Dr. Klaas and staff may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and accounting information) to another party to permit Dr. Klaas and staff to perform its administrative duties, provide me with eye care services and products, process my vision and eye medical benefit claims and communicate with me regarding vision and eye health care services provided by Doc. and staff (for example, mailing of exam reminders or information about updated news and services by Dr. Klaas and staff.)

I can be assured that doctors & staff do not sell my personal health information of any kind to a third party for such party's use.

III. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: ___________________________ Date: ___________________
Print Name: _________________________
(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)
Signature of Representative: ___________________________ Date: __________________________
Print Name: ___________________________ Relationship to Patient:________________________

Authorization to Release Health Information

Patient Name: ____________________________ DOB: _____________________

This release allows Retina Specialists of Indiana to disclose Protected Health Information to Specific individuals who are involved directly or indirectly with your care. Such information includes but is not limited to diagnosis, treatment plans, test results, billing, and appointment information.

________ I do not authorize the release of my Protected Health Information

________ I authorize Retina Specialists of Indiana to release Protected Health

Information about my care to the following individuals:

Name: ____

Relationship: _______________________________ Phone# ________________

Name: ____

Relationship: ____

Please provide any information that you would like to be restricted in the release of your Protected Health Information: ___________________________________

____

I understand that this authorization remains in effect until I notify Retina Specialists of Indiana with any changes in writing. I also understand that it is possible that information released to the authorized receipients could be shared by the authorized recipient at which point would no longer be protected by the Federal HIPPA Privacy Rule.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _________________________________ DATE: _______

PRINTED NAME IF LEGAL GUARDIAN____________________________ RELATIONSHIP TO PT: ________

Dilating Information

Dilating drops are used to dilate or enlarge the pupils of the eye to allow Dr. Klaas to obtain a better view of the back of the eye. Dilation is important in the diagnosis of possible eye diseases or eye complications.

Dilation drops often blur vision for approximately 3-5 hours but could last longer in some patients. It also makes bright lights bothersome. It is not possible to predict how much your vision will be affected so we do recommend that you bring a driver to your dilated appointment. However, if you feel comfortable driving after your dilation, we always give you some disposable sunglasses to help with bright light or you may use your own.

Patient Printed Name: ____

Signature: ____

Date: ________________________________