iSee VisionCare

AN EYE FOR THE FUTURE

Welcome To Our Office!

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Date: _____

Patient Information

Last: _____

First: _____ MI: _____

Street: _____

City: _____ State: _____

Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

How do you prefer to be contacted?

(Indicate #1 and #2 preference):

Home #___Work #___Cell #___Text___Email____

Patient's SSN: _____

Date of Birth: _____ Age: _____

Sex: M F

Employer (or School): _____

Occupation (or Grade): _____

Spouse (or Parent's Name): _____

Spouse (or Parent's Work): _____

If not referred, how did you choose our office?

☐Friend or Relative
☐Another Doctor
☐Insurance List
☐Saw Sign/Building
☐Newspaper/Radio/TV
☐Yellow Pages: Which directory? _____
☐Online Search. If yes, where did you find us? _____

_____

☐Other: _____

Insurance Information

Vision Insurance: _____

Subscriber Name: _____

Subscriber SSN/ID#: _____

Subscriber Birth Date: _____

Primary Medical Insurance: _____

Subscriber Name: _____

Subscriber SSN/ID #: _____

Subscriber Birth Date: _____

Secondary Medical Insurance: _____

Subscriber Name: _____

Subscriber SSN/ID#: _____

Subscriber Birth Date: _____

Do you participate in a flex spending account?

☐Yes ☐No

Lifestyle Questions

Do you...(check all that apply):

☐...use digital devices on a regular basis? If yes, how many hours per day? _____hrs/day
☐...think you might benefit from thinner, lighter lenses?
☐...prefer NOT to wear glasses at times?
☐...spend time outdoors? How often? ____hrs/week
☐...participate in vision-related sports or other activities?

If yes, please specify: _____

_____

_____

Patient Medical History Form

Please complete the following form as thoroughly as possible. The information in this confidential case history form is critical to the evaluation of your vision and health.

Name:_____ Date:_____

Please list all the medications you are currently taking. Please include any over the counter Drugs as well as vitamins.

Eye medications: _____

_____

Systemic medications: _____

_____

_____

_____

_____

_____

_____

Please list any medications you are allergic to:

_____ _____ _____ _____

Please list all eye surgeries:

_____ _____ _____ _____

Please list all major surgeries:

_____ _____ _____ _____

_____ _____ _____ _____

Continued on next page...

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Medical History

Patient Name: _____ **Date:**_____

Primary Care Physician:_____ **Physician's Phone:**_____

OCULAR HISTORY

Please circle "Yes" or "No" as they relate to your ocular history. Please do not leave any blank.

Cataract	.Y .N	Glaucoma	.Y .N	Macular Degeneration	.Y .N
Diabetic Retinopathy	.Y .N	Retinal Detachment	.Y .N	Dry Eye	.Y .N
Lazy Eye (Amblyopia)	.Y .N	Strabismus	.Y .N	Other:_____	

MEDICAL HISTORY

Please circle "Yes" or "No" as they relate to your past medical history. Please do not leave any blank.

Diabetes	.Y .N	Heart Attack/Stent	.Y .N	Thyroid Dis	.Y .N
Stroke	.Y .N	Hypertension	.Y .N	Asthma	.Y .N
MS	Y .N	Coronary Artery Dis	.Y .N	Arthritis	.Y .N
Cancer	Y .N	HIV/AIDS	.Y .N	Other:_____	

FAMILY HISTORY

Please circle all that pertain to your family history.

Blindness	.Mother .Father .Sibling	Diabetes	.Mother .Father .Sibling
Cataract	.Mother .Father .Sibling	Hypertension	.Mother .Father .Sibling
Glaucoma	.Mother .Father .Sibling	Thyroid Dis	.Mother .Father .Sibling
Retinal Detachment	.Mother .Father .Sibling	Other:_____	
Macular Degeneration	Mother Father Sibling		

SOCIAL HISTORY

Please circle "Yes" or "No" as they relate to your social history. Please do not leave any blank.

Marital Status .Married .Single .Divorced .Widow .Widower

Do you drink alcohol? .Y .N Drinks/Day:_____

Do you smoke? .Y .N Packs/Day:_____ If you've quit, how long ago? _____

Occupation? _____

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REVIEW OF SYSTEMS

Patient Name:_____ Date:_____

Please circle "Yes" or "No" as they relate to your health. Please do not leave any blank.

CONSTITUTIONAL

Weight Loss .Y .N
Fever .Y .N
Fatigue .Y .N
Change in Appetite .Y .N
Other: _____

EAR/NOSE/THROAT

Vertigo .Y .N
Frequent Sore Throat .Y .N
Hoarseness .Y .N
Frequent Nosebleeds .Y .N
Other: _____

GENITOURINARY

Pain Urinating .Y .N
Burning Y .N
Frequency .Y .N
Nighttime .Y .N
Blood In Urine .Y .N
Other: _____

RESPIRATORY

Shortness of Breath .Y .N
Coughing Blood .Y .N
Wheezing .Y .N
Persistent Cough .Y .N
Frequent Infections .Y .N
Other: _____

GASTROINTESTINAL

Abdominal Pain .Y .N
Nausea/Vomiting .Y .N
Heartburn .Y .N
Diarrhea .Y .N
Constipation .Y .N
Bloody/Black Stool .Y .N
Other: _____

CARDIOVASCULAR

Chest Pain .Y .N
Palpitations .Y .N
Shortness of Breath .Y .N
Swelling .Y .N
Other: _____

HEMATOLOGIC

Bruising .Y .N
Excessive Bleeding .Y .N
Enlarged Lymph Nodes .Y .N
Other: _____

ALLERGIC/IMMUNE

Hives .Y .N
Hay Fever .Y .N
Other: _____

PSYCHIATRIC

Anxiety .Y .N
Depression .Y .N

MUSCULOSKELETAL

Joint Pain/Swelling .Y .N
Joint Stiffness .Y .N
Muscle Pain .Y .N
Back Pain Y .N
Other: _____

NEUROLOGICAL

Headaches .Y .N
Migraines .Y .N
Numbness .Y .N
Seizures .Y .N
Loss of Strength .Y .N
Tremors .Y .N
Memory Loss .Y .N
Other: _____

SKIN

Rash/Sores Y .N
Lesions .Y .N
Other: _____

EYES

Blurred Vision Y .N
Double Vision Y .N
Sudden Vision Loss .Y .N
Eye Pain .Y .N
Other: _____

Binocular Vision Dysfunction Questionnaire (BVDQ)

Vision Specialists of Michigan

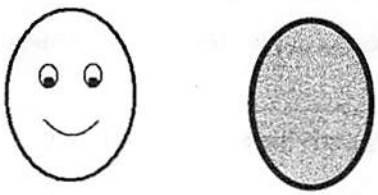
2550 South Telegraph Road, Suite 100 Bloomfield Hills, Michigan 48302
(248) 258-9000 www.VSofM.com

Name: _____ **Email:** _____ **Date:** _____

Best phone number: _____ **Back-up phone number:** _____

Directions: For each of the following questions, please check the answer that best describes your situation. If you wear glasses or contact lenses, answer the questions assuming that you are wearing them.

Always = Everyday
Frequently = At least 1 time / week
Occasionally = Less than 1 time / week
Never = Never

	✓ALWAYS	✓FREQUENTLY	✓OCCASIONALLY	✓NEVER
1. Do you have headaches and / or facial pain?				
Draw in location of discomfort (Scale 1-10: 1=extremely mild, 10=extremely severe)  **FACE** **BACK OF HEAD**				
2. Do you have pain in your eyes with eye movement?				
3. Do you experience neck or shoulder discomfort?				
4. Do you have dizziness and / or lightheadedness?				
5. Do you experience dizziness, light-headedness, or nausea while performing close-up activities (i.e. - computer work, reading, writing)?				
6. Do you experience dizziness, light-headedness, or nausea while performing far-distance activities (i.e. - driving, television, movies)?				
7. Do you experience dizziness, light-headedness, or nausea when bending down and standing back up, or when getting up quickly from a seated position?				
8. Do you feel unsteady with walking, or drift to one side while walking?				
9. Do you feel overwhelmed or anxious while walking in a large department store (i.e. – Target, Wal-Mart, Meijer)?				
10. Do you feel overwhelmed or anxious when in a crowd?				
11. Does riding in a car make you feel dizzy or uncomfortable?				
12. Do you experience anxiety or nervousness because of your dizziness?				

	✓ALWAYS	✓FREQUENTLY	✓OCCASIONALLY	✓NEVER
13. Do you ever find yourself with your head tilted to one side?				
14. Do you experience poor depth perception or have difficulty estimating distances accurately?				
15. Do you experience double / overlapping / shadowed vision at far distances?				
16. Do you experience double / overlapping / shadowed vision at near distances?				
17. Do you experience glare or have sensitivity to bright lights?				
18. Do you close or cover one eye with near or far tasks?				
19. Do you skip lines or lose your place while reading (do you use your finger or a ruler or other guides to maintain your position on the page)?				
20. Do you tire easily with close-up tasks (computer work, reading, writing)?				
21. Do you experience blurred vision with far-distance activities (i.e. - driving, television, movies, chalkboard at school)?				
22. Do you experience blurred vision with close-up activities (i.e. - computer work, reading, writing)?				
23. Do you blink to "clear up" distant objects after working at a desk or working with close-up activities (i.e. - computer work, reading, writing)?				
24. Do you experience words running together with reading?				
25. Do you experience difficulty with reading or reading comprehension?				

Have you ever been diagnosed with:

Traumatic brain injury or concussion? ☐Y ☐N Lazy eye? ☐Y ☐N Reading disability? ☐Y ☐N

Have you ever had an eye operation? ☐ YES ☐ NO

On an average day, how much are you bothered by the 8 symptoms listed listed below? (Rate each symptom from 0 to 10, where 10 is the worst it could be, and where 0 means you have none of that symptom)

Dizziness = / 10
Nausea = / 10
Anxiety = / 10
Headache = / 10
Neckache = / 10
Unsteady with walking = / 10
Sensitivity to light = / 10
Reading difficulty = / 10

Please record any additional symptoms you may be experiencing or specific concerns that you have about your eyes / vision:

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Retinal Photo Consent Form

At iSee VisionCare, Dr. Sonneberg strives to bring you all the latest technology to help ensure that your eyes stay healthy for the future. That is why we offer you an elective picture to be taken of the back of the eye, the retina. This picture allows Dr. Sonneberg to pick up disease at a much faster rate. It can help her manage and diagnose glaucoma, macular degeneration, diabetic eye disease, high blood pressure, elevated cholesterol and many other diseases that could affect the vision in your eyes.

This procedure is not covered under your insurance because it is a screening tool. Dr. Sonneberg likes to have this picture taken on every patient for their yearly eye exam. Again, this picture allows Dr. Sonneberg to help ensure that your eyes stay healthy. There is a **$39** fee for this photo.

Please sign below to let the Dr. Sonneberg know that you would like to have this elective photo taken.

Patient Signature _____

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have reviewed/received a copy of
Patient Name
iSee VisionCare's Notice of Privacy Practices.

_____ _____
Signature of Patient / Guardian Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: