

PATIENT INFORMATION SHEET

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____

AGE: _____ BIRTH DATE: ____/____/____ MALE/FEMALE: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ HOME PHONE: (____) _____

S.S. # _____ PLACE OF EMPLOYMENT _____ OCCUPATION: _____

WORK PHONE: (____) _____ CELL PHONE: (____) _____ MARITAL STATUS: _____

CURRENT E-MAIL ADDRESS: _____

NEXT OF KIN OR RESPONSIBLE PARTY: (Name) _____ (Relationship) _____

ALTERNATE PHONE: (____) _____

RACE: WHITE BLACK AFRICAN ASIAN NATIVE AMERICAN/ALASKAN PACIFIC ISLANDER/HAWAIIAN PATIENT DECLINES

ETHNICITY: HISPANIC NON-HISPANIC PATIENT DECLINES

REFERRING OPTHALMOLOGIST: _____ FAMILY DOCTOR: _____

ADDRESS: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: (____) _____ PHONE: (____) _____

OTHER DOCTOR: _____ OTHER DOCTOR: _____

ADDRESS: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: (____) _____ PHONE: (____) _____

PHARMACY NAME: _____ PHONE: _____ ADDR/CITY: _____

MEDICAL INSURANCE COMPANY AND ADDRESS: (PRIMARY) _____

(SECONDARY) _____

GROUP #: _____ MEDICARE #: _____

IF COVERED UNDER SPOUSE'S/PARENT'S INSURANCE - PLACE OF EMPLOYMENT: _____

POLICY HOLDER/SPOUSE'S BIRTHDATE: ____/____/____ PHONE NUMBER: _____

INSURANCE AUTHORIZATION:

I hereby authorize Midwest Retina Consultants, S.C. to furnish information to insurance carriers concerning my illness and treatments. I hereby authorize benefits for medical services rendered to myself or my dependents to be paid directly to Midwest Retina Consultants, S.C. I am responsible for any amount not covered by my insurance.

DATE: _____ PATIENT SIGNATURE: _____

MIDWEST RETINA CONSULTANTS, S.C.

MEDICAL INFORMATION WAIVER

We will automatically send information regarding your medical condition, as well as recommendations for treatment, to your referring doctor and your medical doctors.

If we need to convey information to you regarding your treatment and medical care, and if you are unavailable when we call, may we leave medical information on your answering machine or voicemail?

_____ Yes _____ No _____ N/A

It is our policy to share medical information with your children and spouse. Do you give us permission to notify your children or spouse? Indicate below.

_____ Yes _____ No _____ N/A

Is there another person with whom you would like us to share medical information?

_____ Yes _____ No

Name: _____

Relationship: _____

Phone #: _____

I have been made aware of the Privacy Policy for this practice.

Name
(print)

Signature

Date

MIDWEST RETINA CONSULTANTS, S.C.

GEORGE J. WYHINNY, M.D.
DANIEL C. ALTER, M.D., Ph.D.
ENRIQUE GARCIA-VALENZUELA, M.D., Ph.D.
BRYAN M. KIM, M.D.
ANAND D. GOPAL, M.D.

RETINA, MACULA AND VITREOUS
DISEASES AND SURGERY
FLUORESCIN ANGIOGRAPHY

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eyes to allow Dr. Wyhinny/Dr. Alter/Dr. Garcia/Dr. Kim/Dr. Gopal to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person, and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself if your vision is affected.

Adverse reaction, such as acute-closure glaucoma, may be triggered from the dilating drops. This is very uncommon and treatable with immediate medical attention.

1. I understand that the dilating drops are necessary to diagnose and monitor my condition, and will likely be used for all my visits in the future.
2. I hereby authorize Dr. Wyhinny/Dr. Alter/Dr. Garcia/Dr. Kim/Dr. Gopal and/or such assistants as me designated by them to administer dilating eyedrops to my eyes.

Patient (or person authorized to sign for patient.)

Date

**PATIENT HISTORY
PAST EYE HISTORY**

Have you had any of the following diseases:

	<u>YES</u>	<u>NO</u>	<u>RIGHT EYE</u>	<u>LEFT EYE</u>	<u>NUMBER OF YEARS</u>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetic Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Tear/Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (Please explain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

HAVE YOU HAD ANY EYE SURGERY?: (Cataract, Laser, etc.) YES NO

Right Eye: _____ Month/Year _____

Left Eye: _____ Month/Year _____

PLEASE LIST ALL EYE MEDICATIONS/DROPS:

Right Eye: _____

Left Eye: _____

PAST MEDICAL HISTORY

HAVE YOU EVER BEEN TOLD THAT YOU HAVE OR HAD ANY OF THE FOLLOWING:

	<u>YES</u>	<u>NO</u>	<u>HOW MANY YEARS</u>
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART PROBLEMS (WHAT KIND?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	_____
CANCER (WHAT KIND?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER MEDICAL (please explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____

ARE YOU TAKING ANY MEDICATIONS? YES NO

If YES, please list all medications with names, dosage, frequency, and route on provided Medication list.

Have you ever had any surgery: YES NO If yes, please provide date and reason: _____

Have you ever been hospitalized: YES NO If yes, please provide date and reason: _____

REVIEW OF SYSTEMS

(CURRENT PROBLEMS)

YES NO

If yes, please explain:

Do you **currently** have any of the following problems:

- Eye Problems _____
- Chronic fever, unexpected weight loss/gain, fatigue _____
- Ear/nose throat problems (e.g. hearing loss, sinus problems)..... _____
- Heart problems (e.g. chest pain, irregular heart beat)..... _____
- Respiratory problems (e.g. shortness of breath, wheezing, coughing) _____
- Gastrointestinal problems (e.g. abdominal pain, diarrhea) _____
- Urinary problems (e.g. pain or discomfort, blood in urine) _____
- Skin problems (e.g. rashes, excessive dryness) _____
- Hematological (e.g. blood problems) _____
- Musculoskeletal problems (e.g. muscle aches, arthritis) _____
- Neurologic problems (e.g. numbness, weakness, headaches, paralysis) . _____
- Psychiatric problems (e.g. depression, anxiety) _____
- Endocrine (e.g. diabetic, thyroid disease) _____

FAMILY HISTORY

YES NO

Do any medical or eye diseases run in your family:

<u>DISEASE</u>	<u>YES</u>	<u>NO</u>	<u>Relationship to patient (Parents, brothers, sisters, children)</u>
Macular Degeneration:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed

Present occupation:

What kind of work have you done in the past?

Do you drink alcohol? Yes No If yes, how many glasses daily:

Do you use street drugs? Yes No If yes, please indicate what:

Do you smoke? Yes No If yes, how many packs daily:

If no, did you ever smoke: Yes No

Have you ever had any of the following sexually transmitted diseases:

Gonorrhea Yes No Syphilis Yes No AIDS/HIV Yes No

Do you have or have ever had Hepatitis? Yes No

Education Level (Please check all that apply):

Grade School High School College graduate Post graduate Other

History Reviewed

