

**MEDICAL HISTORY**

**YOUR NAME:** \_\_\_\_\_

**TODAY'S DATE:** \_\_\_\_\_

**CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS-Why are you here today?**

List all eye health problems/symptoms\*:

\*Medical insurance will only cover if there is a medical reason for the exam such as loss of vision, headaches, eye redness, eye pain, eye itching, glaucoma, cataracts, floaters, dry eyes, etc.

Please answer the following by circling:

Location	Which eye has the problem?	Right eye - Left eye - Both eyes
Quality	Does the problem cause vision loss or blur?	Loss - Blur
Context	Did the problem occur suddenly or gradual?	Sudden - Gradual
Severity	How severe is the problem?	Mild - Moderate - Severe
Modifying Factors	Is it worse at any specific distance?	Distance - Near - Computer
Duration	How long does the problem last?	Intermittent - Constant
Timing	How long has the problem been occurring?	Short term - Long term
Associated Symptoms	Are there associated symptoms?	No - Headache - Pain - Light Sensitivity - Other _____
Previous Interventions	Does anything help the problem?	Nothing helps - Nothing has been tried - Other _____

**PAST, FAMILY AND/OR SOCIAL HISTORY- Please answer the following. Please write NA, if it does not apply.**

(1, 3)

**Personal Medical History:**

Have you had any major illnesses, injuries, or operations? [ ] Y [ ] N Explain: \_\_\_\_\_

Are you taking any medications (prescription and over-the-counter)? [ ] Y [ ] N List: \_\_\_\_\_

Date of Last Medical Exam: \_\_\_\_\_ Doctor: \_\_\_\_\_ For women: Pregnant/nursing? [ ] Y [ ] N

**Family Health History: Please circle any condition in your family history and indicate relative affected.**

Glaucoma _____	Corneal Problem _____	Diabetes _____
Macular Degen _____	Crossed eyes _____	Heart Disease _____
Retinal Problem _____	Lazy eye _____	High Blood Pressure _____

**Social History:** Your occupation/grade: \_\_\_\_\_ Place of employment/school: \_\_\_\_\_

List your sports, hobbies, or special visual needs: \_\_\_\_\_

How many hours do use a computer a day? \_\_\_\_\_ Have you been exposed to Herpes, HIV, TB, Hepatitis? [ ] Y [ ] N

Do you use tobacco products? [ ] Y [ ] N Do you drink alcohol? [ ] Y [ ] N Do you use recreational drugs? [ ] Y [ ] N

Please list all family members in your household: \_\_\_\_\_ age: \_\_\_\_\_ age: \_\_\_\_\_ age: \_\_\_\_\_

**REVIEW OF SYSTEMS - Check inside the boxes if you have a problem with any of the following:**

(1, 2, 10)

Eyes	Y	N	Allergic/Immunologic	Y	N	Genitourinary	Y	N
Loss of vision	[ ]	[ ]	Hay fever/Allergies	[ ]	[ ]	Genitals	[ ]	[ ]
Blurred vision	[ ]	[ ]	Medicine allergies	[ ]	[ ]	Kidneys or Bladder	[ ]	[ ]
Double vision	[ ]	[ ]	Lupus	[ ]	[ ]	<b>Hematologic/Lymphatic</b>		
Cataracts	[ ]	[ ]	Sjogrens	[ ]	[ ]	Anemia	[ ]	[ ]
Crossed eyes	[ ]	[ ]	<b>Constitutional symptoms</b>			High cholesterol	[ ]	[ ]
Flashes	[ ]	[ ]	Fever	[ ]	[ ]	<b>Integumentary</b>		
Floaters	[ ]	[ ]	Recent Weight loss	[ ]	[ ]	Skin	[ ]	[ ]
Dry eyes	[ ]	[ ]	<b>Cardiovascular</b>			Breast	[ ]	[ ]
Watery eyes	[ ]	[ ]	Heart disorder	[ ]	[ ]	<b>Musculoskeletal</b>		
Red eyes	[ ]	[ ]	High blood pressure	[ ]	[ ]	Arthritis	[ ]	[ ]
Mucous discharge	[ ]	[ ]	Vascular disease	[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]
Burning or itching	[ ]	[ ]	<b>Ears, Nose, Mouth, Throat</b>			Muscle pain/Joint pain	[ ]	[ ]
Sandy or gritty feeling	[ ]	[ ]	Sinus problems	[ ]	[ ]	<b>Neurological</b>		
Eye pain or soreness	[ ]	[ ]	Dry throat/mouth	[ ]	[ ]	Headaches	[ ]	[ ]
Light sensitivity	[ ]	[ ]	Chronic ear infections	[ ]	[ ]	Migraines	[ ]	[ ]
Chronic eye infections	[ ]	[ ]	<b>Endocrine</b>			Seizures	[ ]	[ ]
Tired eyes/Eyestrain	[ ]	[ ]	Diabetes	[ ]	[ ]	Multiple Sclerosis	[ ]	[ ]
Halos/Glare	[ ]	[ ]	Thyroid problems	[ ]	[ ]	<b>Psychiatric</b>		
Previous Vision Therapy	[ ]	[ ]	Other glands	[ ]	[ ]	Nervous disorders	[ ]	[ ]
Previous Eye surgery	[ ]	[ ]				Depression	[ ]	[ ]
Previous Eye injury	[ ]	[ ]				<b>Respiratory</b>		
Retinal detachment	[ ]	[ ]				Asthma	[ ]	[ ]
Glaucoma	[ ]	[ ]				Shortness of breath	[ ]	[ ]
						Emphysema	[ ]	[ ]
						Lung cancer	[ ]	[ ]

If you answered yes to eye injury or eye surgery, please explain: \_\_\_\_\_

If you answered YES to diabetes, when were you diagnosed? \_\_\_\_\_

List your last Blood Sugar: \_\_\_\_\_

List your last Hemoglobin A1C: \_\_\_\_\_

List any other medical conditions not listed above: \_\_\_\_\_



# Arizona's Vision

In order to enhance, preserve and protect your eyesight for the rest of your life, please tell us a little about your lifestyle and your needs.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

What brought you to our office today? \_\_\_\_\_

Are you experiencing any vision problems? \_\_\_\_\_

If you didn't have to be here today, what would you rather be doing? \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Environment: Check ALL that apply

- In an office       Travel (flying/driving/both)
- From home       Outside
- Other \_\_\_\_\_

How many hours per week do you spend doing the following:

- At a Computer/TV \_\_\_\_\_ hrs per week
- Outdoors \_\_\_\_\_ hrs per week
- Driving (daytime) \_\_\_\_\_ hrs per week
- Driving (nighttime) \_\_\_\_\_ hrs per week
- Current Hobbies \_\_\_\_\_ hrs per week
- Reading \_\_\_\_\_ hrs per week

My current hobbies include:

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Computer      | <input type="checkbox"/> Reading     | <input type="checkbox"/> Golf                         |
| <input type="checkbox"/> Fishing       | <input type="checkbox"/> Walking     | <input type="checkbox"/> Woodwork/Carpentry           |
| <input type="checkbox"/> Soccer        | <input type="checkbox"/> Biking      | <input type="checkbox"/> Camping/Hiking               |
| <input type="checkbox"/> Tennis        | <input type="checkbox"/> Sewing      | <input type="checkbox"/> Baseball/Softball            |
| <input type="checkbox"/> Football      | <input type="checkbox"/> Basketball  | <input type="checkbox"/> Playing musical instrument   |
| <input type="checkbox"/> Movies/TV     | <input type="checkbox"/> Hunting     | <input type="checkbox"/> Skiing/Snowboarding          |
| <input type="checkbox"/> Running       | <input type="checkbox"/> Swimming    | <input type="checkbox"/> Skateboard/Scooter           |
| <input type="checkbox"/> Playing cards | <input type="checkbox"/> Bowling     | <input type="checkbox"/> Water Sports/Sailing/Jet Ski |
| <input type="checkbox"/> Travel        | <input type="checkbox"/> Racquetball | <input type="checkbox"/> Shooting sports              |
| <input type="checkbox"/> Gardening     | <input type="checkbox"/> Other _____ |   |

If you currently wear eye glasses, what would you change about them?

- Improve comfort       Sun protection       Lighter weight
- Less glare       Thinner lenses       Improved style
- More durable       Read better       Better PC vision
- Remove bifocals       Better TV/Driving vision
- Other \_\_\_\_\_

Do you experience any of the following?

- Scratchy eyes       Headaches       Red eyes
- Painful eyes       Blurry Vision       Eye Strain
- Loss of sight       Double Vision       Watery eyes
- Twitching Eyelid       Color Blindness       Nearsighted
- Farsighted       Floaters       Frequent Infections
- Other \_\_\_\_\_

How well are you hoping to see with your new prescription?  
\_\_\_\_\_

I am interested in the following:

- Checking if my prescription has changed
- Purchasing new glasses / contacts
- Information on new vision technology
- Information on Laser Vision Correction
- Better vision without surgery / glasses
- Preventing your child's vision from getting worse

Are you bothered by glare or sensitivity to any of the following?

- Night Driving       Fluorescent Lights
- Sunshine       Computer screens
- Light       Driving in sunlight
- Other \_\_\_\_\_

Please take a moment to answer the following questions:

- |   |     |    |
|---|-----|----|
| I wear UV protection glasses (up to UV 400) | YES | NO |
| I am happy with my current prescription     | YES | NO |
| I re-adjust my glasses frequently           | YES | NO |
| I have trouble reading fine print           | YES | NO |
| I have trouble reading large print          | YES | NO |
| I would like to change my eye color         | YES | NO |
| I have had eye surgery                      | YES | NO |
| I prefer daily disposable contact lenses    | YES | NO |
| My quality of vision fluctuates regularly   | YES | NO |
| I will be selecting eye glasses today       | YES | NO |
| I am often exposed to chemicals             | YES | NO |
| I like my current style of glasses          | YES | NO |
| My current glasses are uncomfortable        | YES | NO |

How many prescription glasses do you currently use? \_\_\_\_\_

I wear glasses/contacts for:

- Distance only       Reading only       Distance & Near
- Computer       Safety Sport

I wear:

- Bifocals       Trifocals       Progressive (no line)

I am interested in/have worn lenses that darken in sunlight?

I find that selecting eyeglasses for me is:      Easy      Difficult

I own prescription sunglasses. Are they polarized?      YES      NO

Do you have a sun lens color preference?      YES      NO

Do you know that all eyeglass lenses are NOT the same? The quality of lenses and the optics can vary greatly.

# Acknowledgment of Receipt of Notice of Privacy Practices

Arizona's Vision  
Dr. Mark J. Page & Associates  
15215 S 48<sup>th</sup> St. Suite 180  
Phoenix, AZ 85044

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Patient Name: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_

***Signing this document signifies that you have  
received a copy of our Notice of Privacy Practices.***

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

**I acknowledge that I have received the *Notice of Privacy Practices* from Arizona's Vision.**

\_\_\_\_\_  
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

\_\_\_\_\_  
Relationship to Patient Print Name

Source of Authority: \_\_\_\_\_

## Optomap Imaging

This is an image of the interior, back portion of the eye called the retina; and, for all intents and purposes, this area is responsible for capturing light and photo-chemically transferring the information to the area of the brain where vision takes place.



Potentially you can avoid the blurred vision of dilating drops *and* save 30 minutes today!

Macular Degeneration, Glaucoma, and Diabetes are the leading diseases causing blindness in the US today. To ensure peace of mind we will image your retina to determine your baseline interior eye health. Utilizing this technology, we can be proactive in maintaining your best eye health for your assurance and maintain an accurate historical record. Your fee is \$29. The technician will perform this lightning fast and painless procedure during pretesting.

Accept (Sign): \_\_\_\_\_

I decline Optomap and choose a dilation exam: (Initial) \_\_\_\_\_

Date: \_\_\_\_\_

In the unlikely event your doctor suspects risk, he may elect to dilate.

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# QuantifEYE

Qualitative Understanding and Nutritional Treatment Intervention for the EYE

## To Our Patients,

We continuously strive to provide our patients the very best in eye care services. Recently, we acquired a device that allows us to assess your risk of developing an eye disease called Macular Degeneration. This disease is a leading cause of blindness in adults and there is no adequate treatment; however, it may be managed if caught early, with the use of dietary supplements and ultraviolet protection. We can now take measures to reduce your risk of developing this disease. The test is a light response test that only takes a few minutes. We now screen all patients 19 years and older, and develop a baseline measurement that allows us to track any changes that might occur in the future.

### Risk Factors *(please check all that apply)*

- Age: \_\_\_\_\_
- Family History of:  Macular Degeneration,  Glaucoma,  Cataract,  High Blood Pressure,  Diabetes,  Heart Disease
- Smoker
- Former smoker, year quit \_\_\_\_\_
- If You have:  Glaucoma,  Cataract,  High Blood Pressure,  Diabetes,  Heart Disease
- Sensitive to light
- Excessive exposure to the sun
- Female
- Light eyes, light skin
- Inadequate consumption of green, leafy vegetables

We strongly recommend that you take this test so we can assess your risk for Macular Degeneration, and develop a base-line measurement that allows us to track any changes that might occur in the future. Since this is a new test, never before available, it is not covered by your insurance. The cost to you will be \$14.00. We feel its well worth the cost as it may offer you additional protection against a very devastating disease. For a 6 month Quantifeye re-evaluation there is a \$29.00 fee.

Should you have any questions, please do not hesitate to ask.

I understand my risk factors for Macular Degeneration and choose to:

- ACCEPT TEST
- DECLINE TEST

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### For Office Use

#### Risk Assessment:

#### Doctor's Risk Determination

(circle one)	High	Med	Low

MPOD Score \_\_\_\_\_ R/L

<.25	.25 - .45	>.45
Lower Range	Mid Range	Higher Range