Welcome to Optometric Physicians Northwest
Low Vision

Today's Date:____

Referred by:____

Full Name:____

Date of Birth:____

Social Security Number:______________________________________

Mailing Address:____

____

Phone Number:____

Email Address:____

Occupation:____

Emergency Contact:____

Phone Number:____

Current Medications (Prescription and Supplement)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request I writing that you restrict how my private information us used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do then you are bound to abide by such restrictions.

Patient Name: ____

Relationship: ____

Signature: ____

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 as documented below:

Date:	Reason:	Initials:

Eye Symptoms

Floaters	[Y]	[N]
Flashers	[ ]	[ ]
Retinal Detachment	[ ]	[ ]
Glaucoma	[ ]	[ ]
Loss of Vision	[ ]	[ ]
Blurred vision	[ ]	[ ]
Double vision	[ ]	[ ]
Cataracts	[ ]	[ ]
Crossed eyes	[ ]	[ ]
Dry eyes	[ ]	[ ]
Watery eyes	[ ]	[ ]
Red eyes	[ ]	[ ]
Burning or itching	[ ]	[ ]
Sandy or gritty feeling	[ ]	[ ]
Eye pain or soreness	[ ]	[ ]
Light sensitivity	[ ]	[ ]
Tired/Strained eyes	[ ]	[ ]
Halos/Glare	[ ]	[ ]
Previous Vision Therapy	[ ]	[ ]
Previous Eye Injury	[ ]	[ ]
Previous Eye Surgery	[ ]	[ ]

Condition	[Y]	[N]
Allergic/Immunologic		
Hay fever/Allergies	[ ]	[ ]
Medicine allergies	[ ]	[ ]
Lupus	[ ]	[ ]
Sjogren's	[ ]	[ ]
Constitutional Symptoms		
Fever	[ ]	[ ]
Recent Weight Loss	[ ]	[ ]
Cardiovascular		
Heart Disorder	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Vascular Disease	[ ]	[ ]
Ear/ Nose/ Mouth/ Throat		
Sinus Problems	[ ]	[ ]
Dry Throat/Mouth	[ ]	[ ]
Chronic Ear Infections	[ ]	[ ]
Endocrine		
Diabetes	[ ]	[ ]
Thyroid Problems	[ ]	[ ]
Other Glands	[ ]	[ ]
Genitourinary		
Genital Disease	[ ]	[ ]
Diarrhea	[ ]	[ ]
Hematologic/ Lymphatic		
Anemia	[ ]	[ ]
High Cholesterol	[ ]	[ ]
Integumentary		
Skin	[ ]	[ ]
Breast	[ ]	[ ]
Psychiatric		
Nervous Disorder	[ ]	[ ]
Depression	[ ]	[ ]

Condition	[Y]	[N]
Musculoskeletal		
Arthritis	[ ]	[ ]
Rheumatoid Arthritis	[ ]	[ ]
Muscle/Joint Pain	[ ]	[ ]
Neurological		
Headaches	[ ]	[ ]
Migraines	[ ]	[ ]
Seizures	[ ]	[ ]
Multiple Sclerosis	[ ]	[ ]
Respiratory		
Asthma	[ ]	[ ]
Shortness of Breath	[ ]	[ ]
Emphysema	[ ]	[ ]
Lung Cancer	[ ]	[ ]

If YES to high blood pressure, when was your last measurement?______________________________

If YES to diabetes, when were you diagnosed?

____

Your last blood sugar:________________________

Your last Hemoglobin A1C:___________________

Any other conditions not listed:_______________

____

MEDICAL HISTORY

Chief Complaint – Why are you here today?______________________________

____

All eye health problems/symptoms:______________________________

Please answer the following by circling

*Medical insurance can only be billed if there is a medical reason for the exam such as vision loss, headaches, eye redness, eye pain, eye itching, glaucoma, cataracts, flashes or floaters, dry eye, ect.

Which eye has the problem?	Right – Left – Both
Does the problem cause vision loss or blur?	Loss – Blur
Did the problem occur suddenly or gradual?	Sudden – Gradual
How severe is the problem?	Mild – Moderate – Severe
Is it worse at any specific distance?	Distance – Near – Computer
How long does the problem last?	Intermittent – Constant
How long has the problem been occurring?	Short term – Long term
Are there associated symptoms?	No – Headache – Pain – Light Sensitive
Does anything help the problem?	Yes – No – Nothing tried