LIFESTYLE QUESTIONNAIRE

PATIENT NAME ______________________ DATE __________

We recognize that your eyes are very important to you. We would like to know how you use your eyes on a daily basis. Along with your eye exam, this information will assist us in recommending the best options for your eyes and your personal lifestyle.

Do you wear glasses? ❑ Yes ❑ No **If Yes** ❑ All the time ❑ Sometimes

How important is it for you to read or use the computer without glasses?
❑ Very Important ❑ Important ❑ Not Important

How many hours per day do you: Read ________ Use the computer ________

Where do you hold your book when reading?
❑ Close to face ❑ Chest level ❑ In your lap

How do you feel about wearing glasses? ______________________________

____

If it were possible to go without glasses, would you like that? ❑ Yes ❑ No

Do you drive at night? ❑ Yes ❑ No
If yes ❑ Occasionally ❑ Nightly Professionally (truck/cab) ❑ Yes ❑ No

Please check the following activities you do on a regular basis:

❑ Read Newspapers, Books
❑ Drive daytime
❑ Paperwork/Writing
❑ Cell Phone
❑ Computer/Paperwork
❑ Hunt or Fish
❑ Photography
❑ Paint/Artist
❑ Read Medicine Bottles
Other______________________________
❑ Needlepoint
❑ Tennis
❑ Golf
❑ Musician

PATIENT SIGNATURE ______________________ DATE __________

TECH INITIALS __________

EYE CENTER OF TEXAS
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MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME ______________________________ DATE ______________

❑ Male ❑ Female Date of Birth _____/_____/________

Primary Care Physician ______________________________

Referring/Specialty Dr. ______________________________

Pharmacy______________________________ Phone Number______________________

Location ______________________________

RACE ❑ American Indian or Alaska Native ❑ Black or African American
❑ Asian ❑ White ❑ Native Hawaiian or Other Pacific Islander

ETHNICITY ❑ Hispanic ❑ Not Hispanic

PREFERRED LANGUAGE ❑ English ❑ Spanish ❑ French ❑ Italian
❑ Japanese ❑ Portuguese ❑ Russian

DRUG ALLERGIES ❑ None	REACTION	SEVERITY
______________________	________________	❑ Mild ❑ Moderate ❑ Severe
______________________	________________	❑ Mild ❑ Moderate ❑ Severe
______________________	________________	❑ Mild ❑ Moderate ❑ Severe
______________________	________________	❑ Mild ❑ Moderate ❑ Severe

PAST OCULAR HISTORY ❑ No history of eye problems
(Mark all that apply)

❑ Cataracts	❑ Hyperopia (Far sighted	❑ Myopia (Near sighted)
❑ Amblyopia (Lazy eye)	❑ Diabetic Retinopathy	❑ Optic Neuritis
❑ Iritis	❑ Aphakia	❑ Dry Eyes
❑ Keratoconus	❑ Retinal Detachment	❑ Astigmatism
❑ Glaucoma	❑ Macular Degeneration	

Other____

____

____

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Medical History - con't.

OCULAR SURGERIES ❏ No prior ocular surgery
(Mark all that apply)

R - L	R - L	R - L	R - L
❏ ❏ Foreign Body Removal	❏ ❏ Punctal Plugs	❏ ❏ Laser	❏ ❏ Cataract Surgery
❏ ❏ Blepharoplasty	❏ ❏ Retinal Laser Surgery	❏ ❏ RK	❏ ❏ LASIK
❏ ❏ Strabismus Surgery	❏ ❏ Corneal Transplant	❏ ❏ Vitrectomy	❏ ❏ PRK

Other______________________________

CURRENT EYE MEDICATIONS (Please list all)

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

OTHER MEDICAL HISTORY ❏ No history of illnesses

❏ Anemia	❏ Diabetes Type 2	❏ High Blood Pressure	❏ Migraine
❏ Arthritis	❏ Eczema	❏ High Cholesterol	❏ Polymyalgia
❏ Arrhythmia	❏ Fibromyalgia	❏ HIV / AIDS	❏ Psychiatric Disorder
❏ Asthma	❏ Hepatitis A/B/C	❏ Kidney Disease	❏ Skin Cancer
❏ Bleeding Disorder	❏ Herpes Simplex	❏ Kidney Stones	❏ Stroke
❏ Cancer	❏ Hearing Loss	❏ Liver Disease	❏ Thyroid Disease
❏ Congestive Heart Failure	❏ Herpes Zoster/Shingles	❏ Meningitis	❏ Toxoplasmosis
❏ COPD	❏ Histoplasmosis	❏ MRSA	❏ Wound Infection
❏ Dementia/Alzheimer's	❏ Syphillis	❏ Lung Disease	
❏ Diabetes Type 1	❏ Headache	❏ Lupus	

Other______________________________

GENERAL SURGERIES / OPERATIONS (Please list)

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

ALL OTHER MEDICATIONS ❏ None

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

FAMILY HISTORY AND RELATIONSHIP (Father, Mother, Maternal Grandparent, Paternal Grandparent, etc)

❏ Arthritis ❏ Diabetes ❏ Kidney Disease ❏ Stroke ❏ Blindness
❏ Glaucoma ❏ Lazy Eye ❏ TB ❏ Cancer ❏ Heart Disease
❏ Macular Degeneration ❏ Cataracts ❏ High Blood Pressure ❏ Retinal Disease

Other____

SOCIAL HISTORY
(Mark all that apply)

Smoking ❏ current every day smoker ❏ current some day smoker
❏ former smoker ❏ never smoked

Alcohol Use ❏ Yes ❏ No If yes, how much and how often?_______________________

Drug Use ❏ Yes ❏ No If yes, what and how often?_______________________

REVIEW OF SYSTEMS
(Mark all that apply)

EYES
❏ Previous Surgery
❏ Contact Lens
❏ Pain
❏ Double Vision
❏ Glaucoma
❏ Cataracts
❏ Macular Degeneration
❏ Dry Eyes
❏ Flashes
❏ Floaters

EAR, NOSE, AND THROAT
❏ Hard of Hearing
❏ Ringing in Ears
❏ Vertigo

CARDIOVASCULAR
❏ Chest Pain
❏ Dizziness
❏ Fainting Spells
❏ Shortness of Breath
❏ Irregular Heart Beat
❏ Difficulty Lying Flat
❏ Hypertension

CONSTITUTIONAL
❏ Fatigue / Weakness
❏ Fever
❏ Weight Gain / Loss
❏ Headaches

RESPIRATORY
❏ Cough
❏ Congestion
❏ Wheezing
❏ Asthma
❏ Seasonal Allergies

GASTROINTESTINAL
❏ Heartburn
❏ Nausea / Vomiting
❏ Jaundice / Hepatitus
❏ Diarrhea

GENITO-URINARY
❏ Pain / Difficulty
❏ Blood in Urine
❏ History of Kidney Stones
❏ History of STD's

PSYCHIATRIC
❏ Anxiety / Depression
❏ Mood Swings
❏ Difficulty Sleeping
❏ Mental Illness

ENDOCRINE
❏ Increased Thirst
❏ Increased Hunger
❏ Increased Urination
❏ Increased Sweating
❏ Fingernail Changes
❏ Diabetes
❏ Thyroid

BLOOD / LYMPHNODES
❏ Easy Bruising
❏ Gums Bleed Easy
❏ Prolonged Bleeding
❏ Heavy Aspirin Use
❏ Anemia
❏ Sickle Cell

MUSCULOSKELETAL
❏ Stiffness
❏ Arthritis
❏ Joint Pain / Swelling

SKIN
❏ Rash / Sores
❏ Lesions
❏ Hives / Eczema

NEUROLOGICAL
❏ Seizures
❏ Weakness / Paralysis
❏ Numbness
❏ Tremors

IMMUNOLOGIC
❏ Hives
❏ Itching
❏ Runny Nose
❏ Sinus Pressure

RIGHT EYE VISUAL ASSESSMENT

PATIENT NAME ______________________ DATE __________

VISUAL FUNCTIONING **Does your vision cause a problem for you to . . .**

Read A Newspaper	❏ Always	❏ Sometimes	❏ Never
Read Cell Phone/Tablet	❏ Always	❏ Sometimes	❏ Never
See Traffic Signs	❏ Always	❏ Sometimes	❏ Never
Read Labels	❏ Always	❏ Sometimes	❏ Never
Read Price Tags	❏ Always	❏ Sometimes	❏ Never
Recognize People	❏ Always	❏ Sometimes	❏ Never
See Steps	❏ Always	❏ Sometimes	❏ Never
See Street Curbs When Walking	❏ Always	❏ Sometimes	❏ Never
Watch TV	❏ Always	❏ Sometimes	❏ Never
Work At Your Job	❏ Always	❏ Sometimes	❏ Never
Manage Your Home	❏ Always	❏ Sometimes	❏ Never
Enjoy Recreation & Leisure	❏ Always	❏ Sometimes	❏ Never

SYMPTOMS **Have you been bothered by any of the following?**

Difficulty reading	❏ Always	❏ Sometimes	❏ Never
Difficulty seeing computer screen	❏ Always	❏ Sometimes	❏ Never
Poor night vision	❏ Always	❏ Sometimes	❏ Never
Seeing halos around lights	❏ Always	❏ Sometimes	❏ Never
Glare	❏ Always	❏ Sometimes	❏ Never
Blurry, hazy vision	❏ Always	❏ Sometimes	❏ Never
Difficulty seeing in poor or dim light	❏ Always	❏ Sometimes	❏ Never

DRIVING

Are you currently able to drive? ❏ Yes ❏ No

If so, during daylight hours ❏ Yes ❏ No If so, during evening hours ❏ Yes ❏ No

Do problems with your sight cause you to be afraid when you drive?

During Daylight Hours ❏ Yes ❏ No During Evening Hours ❏ Yes ❏ No

During the past six months, have you made any driving errors? ❏ Yes ❏ No

OCCUPATION ______________________________

INTERESTS / HOBBIES ______________________________

PATIENT SIGNATURE ______________________ **TECH INITIALS** __________

EYE CENTER OF TEXAS
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LEFT EYE VISUAL ASSESSMENT

PATIENT NAME ____________________ DATE __________

VISUAL FUNCTIONING Does your vision cause a problem for you to . . .

Read A Newspaper	❑ Always	❑ Sometimes	❑ Never
Read Cell Phone/Tablet	❑ Always	❑ Sometimes	❑ Never
See Traffic Signs	❑ Always	❑ Sometimes	❑ Never
Read Labels	❑ Always	❑ Sometimes	❑ Never
Read Price Tags	❑ Always	❑ Sometimes	❑ Never
Recognize People	❑ Always	❑ Sometimes	❑ Never
See Steps	❑ Always	❑ Sometimes	❑ Never
See Street Curbs When Walking	❑ Always	❑ Sometimes	❑ Never
Watch TV	❑ Always	❑ Sometimes	❑ Never
Work At Your Job	❑ Always	❑ Sometimes	❑ Never
Manage Your Home	❑ Always	❑ Sometimes	❑ Never
Enjoy Recreation & Leisure	❑ Always	❑ Sometimes	❑ Never

SYMPTOMS Have you been bothered by any of the following?

Difficulty reading	❑ Always	❑ Sometimes	❑ Never
Difficulty seeing computer screen	❑ Always	❑ Sometimes	❑ Never
Poor night vision	❑ Always	❑ Sometimes	❑ Never
Seeing halos around lights	❑ Always	❑ Sometimes	❑ Never
Glare	❑ Always	❑ Sometimes	❑ Never
Blurry, hazy vision	❑ Always	❑ Sometimes	❑ Never
Difficulty seeing in poor or dim light	❑ Always	❑ Sometimes	❑ Never

DRIVING

Are you currently able to drive? ❑ Yes ❑ No

If so, during daylight hours ❑ Yes ❑ No If so, during evening hours ❑ Yes ❑ No

Do problems with your sight cause you to be afraid when you drive?

During Daylight Hours ❑ Yes ❑ No During Evening Hours ❑ Yes ❑ No

During the past six months, have you made any driving errors? ❑ Yes ❑ No

OCCUPATION ____________________

INTERESTS / HOBBIES ____________________

PATIENT SIGNATURE ____________________ **TECH INITIALS** __________

EYE CENTER OF TEXAS
Leaders in Eye Care

Revised 5/2023

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please read privacy practices on the following page

I acknowledge that I have been provided the opportunity to read a copy of Eye Center of Texas' Notice of Privacy Practices, available on our website at www.eyecenterofexas.com (located under Patient Resources tab) or please ask someone at our front desk to provide you with a copy.

____

PATIENT NAME

______________________________________ ______________

PATIENT SIGNATURE **DATE**

Clinical information will not be provided to anyone other than to you and Eye Center of Texas' Associates as noted in the Notice of Privacy Practices. If you would like us to inform family members or other persons, if any, about your general medical condition and/or your diagnosis (including treatment, payment and health care operations), please list those individuals below.

____

____

____

- ❑ A communications barrier prevented ECT from obtaining acknowledgement
- ❑ An emergency situation prevented ECT from obtaining acknowledgement
- ❑ Individual refused to sign
- ❑ Other ______________________________________

EYE CENTER OF TEXAS
Leaders in Eye Care

Revised 5/2023

PRIVACY PRACTICES

1. WHAT DOES HIPAA STAND FOR?
HIPAA is an acronym for Health Insurance Portability & Accountability Act which was passed by Congress in 1996 and is effective as of April 14, 2003.

2. WHY SHOULD I SIGN NOW?
Signing now simply lets us know you received the HIPAA Notice of Privacy Practices. Of course you can choose not to sign.

3. WHAT HAPPENS IF I DON'T SIGN THIS ACKNOWLEDGEMENT FORM?
First, you need to know we will provide you timely care and treatment whether or not you sign the form. Second, if you choose not to sign the form, we will note your choice on the bottom of the acknowledgement form and hope you take a copy of the Notice.

4. IS MY SIGNATURE JUST ACKNOWLEDGING RECEIPT OF THIS NOTICE?
Yes. By signing this acknowledgement form we then can show the Department of Health & Human Services that we are complying with one of the major rules of HIPAA to make sure we give every patient the opportunity to have our Notice.

5. WHY IS THIS NOTICE SO LONG COMPARED TO THE ONES I RECEIVED FROM MY FINANCIAL INSTITUTION OR MY CREDIT CARD COMPANY OR MY LIFE INSURANCE COMPANY?
Those companies are subject to a different set of privacy rules under the Graham/Leach Act while all healthcare organizations are subject to HIPAA.

6. ARE YOU DOING ANYTHING DIFFERENTLY WITH MY HEALTH INFORMATION NOW THAN YOU DID BEFORE HIPAA?
Actually, we are going to guard your medical information even more closely. We have developed policies and procedures for our staff throughout Eye Center of Texas to follow to make certain your medical information is shared only with those needing your information for treatment, payment, or healthcare operations.

7. IS THIS HIPAA NOTICE AND ACKNOWLEDGEMENT FORM ONLY FOR EYE CENTER OF TEXAS?
Yes; however, all healthcare organizations such as hospitals, physician offices, outpatient surgery centers, and home care or hospice care services are subject to HIPAA effective April 14, 2003. These other organizations will have their own Notice and acknowledgement form you will need to sign when you receive services from them.

8. AFTER I SIGN THIS ACKNOWLEDGEMENT FORM, THEN WHAT HAPPENS?
We will place your form in your medical record and note your choice in our computer system once our new patient care information system is installed throughout our system later this year. In the meantime, when you return for the same type of service or another service here at Eye Center of Texas we will need to ask you if you have received our HIPAA Privacy Notice. Since you have received one today you just need to let us know then that you already have one.

9. WHAT AM I GOING TO BE PAYING OUT BECAUSE OF SIGNING?
Signing our HIPAA Privacy Notice acknowledgement form has NO bearing on your current payment arrangements.

10. AM I EXPECTED TO SIGN THIS ACKNOWLEDGEMENT FORM WITHOUT READING THE PRIVACY NOTICE?
Yes. You are simply going on record that you have the Privacy Notice which we are required by law that is the Health Insurance Portability & Accountability Act, to provide. Your signature does not indicate that you have read the Notice and agree with everything that is in it.

WE WANT YOU TO RECEIVE THE BEST PRICE FOR YOUR RX

To help patients receive the best price for their prescribed eye drops, we have partnered with SENA Pharmacy. SENA specializes in ophthalmology prescriptions and provides patients with the best price and will apply all available discounts from drug manufacturer coupon programs. Plus they will deliver your prescription drops for FREE.

Within 24 hours after you leave our office, please expect a call from SENA Pharmacy at 281-440-0018. Please answer this call because they cannot deliver your drops until you confirm delivery.

PHARMACY INFORMATION

(NOTE: This is for emergencies, after hours and/or weekend Rx needs)

PHARMACY NAME ______________________________

ADDRESS ______________________________

CITY ____________________ **STATE** ______ **ZIP** __________

PHONE NUMBER ______________________________

PRIMARY CARE PROVIDER (PCP) INFOMATION

PCP NAME ______________________________

ADDRESS ______________________________

CITY ____________________ **STATE** ______ **ZIP** __________

PHONE NUMBER ______________________________

PATIENT'S NAME ______________________________

EMAIL ADDRESS ______________________________

DATE OF BIRTH ____________________ **GENDER** ☐ Male ☐ Female

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