The Eye Care Group
Excellence and Compassion in Eye Care

NEURO-OPHTHALMIC QUESTIONNAIRE

NAME: _____ **AGE:** _____

DATE OF EXAM: _____ **CHART #:** _____
(Office Use Only)

1. What is the main problem that you are having? (If additional space is required, please use the back of this page). _____

   _____

2. How long have you had this problem? _____

3. Has it gotten better or worse? _____

4. How severe is it? _____

5. If this occurs intermittently, how frequently does it occur? _____

6. Have you had any other associated signs or symptoms? Yes No

   _____

7. Do you have headaches? Yes No If so, please complete the HEADACHE section on Page 2.

8. Do you have double vision? Yes No If so, please complete the DOUBLE VISION section on Page 3.

9. Did your problem develop after a head injury? Yes No
   A. If so, did you lose consciousness at the time of injury? Yes No

10. Have you had loss of vision? Yes No If you have, please answer the following questions.
    A. Did you have pain on movement of the eye when it began? Yes No

    B. Did the visual loss occur suddenly or gradually? Sudden Gradual Not Sure

    C. Since noting the visual loss, have there been further changes? Yes No

    D. At what time of day did the visual loss occur? _____

    E. Have you had further visual loss? Yes No If so, has it been gradual or progressive?
    _____

    F. If your visual loss is transient, how long does it last? _____

    G. Do you get a headache after the visual loss? Yes No

(Over to Page 2)

H. If you have had sudden visual loss, please answer the following questions:

1. Was the visual loss gradual or sudden? _____

I. Are you having any of the following?:

1. Scalp or temple tenderness? Yes No
2. Pain or tongue, gums, or jaw? Yes No
3. New pain in your shoulder or thighs? Yes No
4. Weight loss, fever, loss of appetite, general sense of malaise or fatigue? Yes No

HEADACHES

1. Are you having headaches? Yes No If yes:
2. When did the headaches start? _____
3. Location of headache: _____
4. Do they wake you up at night? Yes No
5. On a scale of 1 to 10, with 10 being the worse possible pain you could have, how would you rate this headache? _____
6. Type of pain (pounding, pulsating, constant ache, tightness, sharp pain, etc.): _____
7. How many headaches do you get each month? _____

   Are they becoming more frequent? Yes No
8. Do the headaches occur primarily when you read? Yes No
9. Are you having fuzz-outs or blackouts of vision that last for a second or two, particularly with change in head position? Yes No
10. Have you been hearing a swishing noise in either ear? Yes No
11. Have you gained or lost any weight recently? Yes No
12. Are you aware of blurred vision or difficulty seeing to either side? Yes No
13. Are you taking any new medication? Yes No
14. What medicines are you taking for pain? _____

_____

A. Are they helping? Yes No
B. Have you tried other medications? Yes No

   If yes, please list. _____ _____

   _____ _____

(Over to Page 3)

DOUBLE VISION

1. Are you having double vision? Yes No
   Is it better or worse? _____
2. Is the double vision worse at near or distance? _____
3. Does the double vision go away if you cover either eye? Yes No
4. When you have the double vision, are the images side by side or one above the other? _____
5. Are either of the images tilted? Yes No
6. Is the double vision worse in any particular field of gaze, that is, to the right or to the left, up, or down? _____
7. Does the double vision fluctuate with time of day? Yes No _____
8. Is it worse at any particular time of day? Yes No _____
9. Is there any activity that makes it better or worse? Yes No _____
10. Have you ever had double vision previously? Yes No
11. Do you have any associated drooping of your eyelids? Yes No
12. Did the double vision begin after a head injury? Yes No
    A. If so, did you lose consciousness? Yes No
13. Do you have any pain in the eye? Yes No
14. Do you have any other neurologic problems? Yes No
15. Do you have any difficulty with swallowing or hoarseness of your voice? Yes No
16. Do you have any history of thyroid disease? Yes No

(Over to Page 4)

PAST MEDICAL HISTORY: Do you have any history of the following?:

Heart Disease:	____ YES	____ NO	**HYPERTENSION:**	____ YES	____ NO
Angina	____ YES	____ NO	Treated	____ YES	____ NO
Coronary Artery Disease	____ YES	____ NO	Untreated	____ YES	____ NO
Heart Attack	____ YES	____ NO	**CANCER:**	____ YES	____ NO
Atrial Fibrillation	____ YES	____ NO	Type	_____	
Coronary Artery			Location	_____	
Bypass Surgery	____ YES	____ NO	Treatment Date	_____	
Valve Surgery	____ YES	____ NO	**SEIZURES:**	____ YES	____ NO
Pacemaker	____ YES	____ NO	Thyroid Disease:	____ YES	____ NO
Other	____ YES	____ NO	Skin Disease:	____ YES	____ NO
Elevated Cholesterol and/or					
Lipids - Hyperlipidemia	____ YES	____ NO			
Diabetes:	____ YES	____ NO			
Kidney Disease:	____ YES	____ NO			
Arthritis:	____ YES	____ NO			
Headache:	____ YES	____ NO			

Pulmonary Disease:
Asthma – Chronic Pulmonary Disease: ____ YES ____ NO
Sleep Apnea ____ YES ____ NO
Carotid Artery Disease: ____ YES ____ NO
Gastrointestinal Disease: ____ YES ____ NO
Hepatitis ____ YES ____ NO
Urinary Tract Disease: ____ YES ____ NO
Hematologic (Blood) Disease: ____ YES ____ NO
Hearing – Ears, Nose, Throat Problems: ____ YES ____ NO
Neurologic or Psychiatric Disease: ____ YES ____ NO
Major Infections: ____ YES ____ NO
Exposure to Toxic Substances Recently: ____ YES ____ NO
Have You Ever Been Exposed To Any Chemicals?: ____ YES ____ NO
Have You Ever Had Any Tropical Diseases?: ____ YES ____ NO
If yes, when diagnosed: _____
Any Other Information About Medical History Not Included?: ____ YES ____ NO

PAST EYE HISTORY: Do you have any history of:

Cataract	____ YES	____ NO
Glaucoma	____ YES	____ NO
Retinal Detachment	____ YES	____ NO
Eye Surgery	____ YES	____ NO
Cataract Surgery	____ YES	____ NO
Other	____ YES	____ NO
Macular Disease	____ YES	____ NO
Color Blindness	____ YES	____ NO
Previous Eye Injuries	____ YES	____ NO
Double Vision	____ YES	____ NO
Strabismus		
(Eyes Turning In or Out)	____ YES	____ NO
Amblyopia / Lazy Eye	____ YES	____ NO
Eye Surgery	____ YES	____ NO
Other	____ YES	____ NO

If you wear glasses, how old were you when you started? _____
How old are your glasses ? _____

Any other information about **your medical history** not included? ____ YES ____ NO

_____

(Over to Page 5)

Please list all the MEDICATIONS you are taking. Include any herbal products, over-the-counter medications, vitamins. Also please indicate if you take Viagra or any other similar medication.

NAME OF DRUG / DROP	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list **ALLERGIES** to medications

_____ _____ _____

_____ _____ _____

Please list all **SURGERIES and HOSPITALIZATIONS** (with dates) since childhood.

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY:

Occupation: _____

Employer: _____

Address: _____

Phone: _____ Cell Phone: _____

E-Mail Address: _____

If retired, what did you do previously? _____

Tobacco: Do you smoke or have you ever smoked? Yes No

At what age did you begin? _____

How much do you or did you smoke? _____

When did you stop? _____

Alcohol: Never _____ Occasionally _____

More than three drinks per day? Yes No

Have you ever been a heavy drinker? Yes No

If so, when did you stop? _____

Have you ever been addicted to alcohol? Yes No

Diet: Do you eat a balanced diet? Yes No

Do you have any diet restrictions? Yes No

Marital History: ____ Single ____ Married ____ Divorced ____ Widowed ____ Sep

Travel: Have you traveled out of the country in the last five years? Yes No

If yes, please list locations: _____ _____ _____ _____

Pets: Do you own any pets? Yes No If yes, what type? _____

Have any of them been ill? Yes No

Immunizations: Have you had any immunizations recently? Yes No

If the patient is under 18, the following additional information needs to be completed.

BIRTH HISTORY: ***(If the answer is "yes", please provide information).***

Was the patient premature? ____ YES ____ NO

Birth weight: _____ Weeks of gestation: _____

Were there any problems with the pregnancy? ____ YES ____ NO

Was there any trouble with delivery? ____ YES ____ NO

Were there any breathing or feeding problems in the first few months? ____ YES ____ NO

Was there any trouble or delayed sitting, walking, talking, or development? ____ YES ____ NO

Are there are unresolved school difficulties? ____ YES ____ NO

Has the patient's growth and development, such as fine motor control, gross motor control, speech, etc., been within normal limits? ____ YES ____ NO

(Over to page 6)

REVIEW OF SYSTEMS Do you have a history of any problems in the following areas?

CONSTITUTIONAL SYMPTOMS
Weight Loss _____YES _____NO
Fever _____YES _____NO
Fatigue _____YES _____NO

EAR, NOSE, MOUTH, THROAT
Difficulty Hearing _____YES _____NO

RESPIRATORY
Chronic Cough _____YES _____NO
Shortness of Breath _____YES _____NO
Sleep Apnea _____YES _____NO

CARDIOVASCULAR
Angina or Chest Pain _____YES _____NO
Rapid or Irregular Heartbeat _____YES _____NO
Heart Attack _____YES _____NO
Bypass Surgery _____YES _____NO
Cardiac Stents _____YES _____NO

GASTROINTESTINAL
Stomach Ulcer _____YES _____NO
Diarrhea _____YES _____NO
Hepatitis _____YES _____NO
Other _____

GENITOURINARY
Enlarged Prostate ____ YES ____ NO
Frequent Urination ____ YES ____ NO
Sexually Transmitted Disease ____ YES ____ NO

SKIN
Rash _____YES _____NO
Itchy Skin _____YES _____NO

ENDOCRINE
Excessive Thirst _____YES _____NO
Heat Intolerance _____YES _____NO

NEUROLOGICAL
Seizures ____ YES ____ NO
Dizziness ____ YES ____ NO
Migraine ____ YES ____ NO
Difficulty Swallowing ____ YES ____ NO
Headaches ____ YES ____ NO

MUSCULOSKELETAL
Muscle Pain _____YES _____NO
Joint Pain _____YES _____NO

PSYCHOLOGICAL
Depression _____YES _____NO
Anxiety _____YES _____NO

HEMATOLOGICAL/LYMPHATIC
Anemia _____YES _____NO
Other _____

HIV/AIDS _____YES _____NO

GYNECOLOGICAL
Are you pregnant? _____YES _____NO
If yes; due date: _____

DRUG USE _____YES _____NO
Addiction _____YES _____NO

Speech Problems ____ YES ____ NO
Stroke ____ YES ____ NO
Carotid Artery Surgery ____ YES ____ NO
Weakness of Arms/Legs ____ YES ____ NO
Numbness ____ YES ____ NO

EYES
See past eye history (page no. _____)

Do you have any medical problems or symptoms we have not asked you about? _____YES _____NO
If "yes", please provide additional information.

_____

_____

(Over to page 7)

FAMILY HISTORY: **AGE** **HEALTH** **ILLNESSES**

Mother: _____

_____

Father: _____

_____

Brothers / Sisters: _____

_____

Children: _____

_____

_____

Other Family Members: _____

_____

FAMILY HISTORY: ***(If the answer is "yes", please provide information).***

Do any of the following run in your family:

Crossed eyes	____ YES	____ NO
Amblyopia (lazy eye)	____ YES	____ NO
Birth defects	____ YES	____ NO
Neurological disease	____ YES	____ NO
Other childhood diseases	____ YES	____ NO

NAME	RELATION	DISEASE

Is there any family history of neurologic or eye disease other than needing to wear glasses?
Yes No _____

Number of siblings and their ages:

_____ _____ _____ _____

_____ _____ _____ _____

Is there any other aspect of your MEDICAL **HISTORY** that you have not included?
Yes No _____

Reviewed By:

Tech's Initials: _____ Date: _____ Dr.'s Initials: _____ Date: _____

The Eye Care Group
Excellence and Compassion in Eye Care

NEURO-OPHTHALMIC PATIENT INFORMATION FORM

Chart #: _____ **Date:** _____
(OFFICE USE ONLY)

NAME: _____ M ____ F ____ AGE: _____

ADDRESS: _____
Box or Street City State Zip

BIRTH DATE: _____ **S.S. #:** _____

Please Circle: *This information is requested due to Healthcare Reform laws dictated by Congress.*

Race: American Indian Asian Black Multi-racial Native Hawaiian White

Ethnicity: Hispanic/Latino Non-Hispanic/non-Latino

Preferred Language: English Spanish Other: _____

HOME PHONE: _____ **WORK PHONE:** _____

CELL PHONE: _____ **E-MAIL:** _____

MARITAL STATUS: Married _____ Single _____ Divorced _____ Widowed _____ Sep _____

EMERGENCY CONTACT: _____
(Name and number of person other than spouse or guardian)

FAMILY PHYSICIAN: _____ **CITY:** _____

Whom can we thank for recommending us?

Name:_____ Address:_____
City:_____ State:_____ Zip Code: _____

Preferred Method of Payment: _____ Cash _____ Check _____ VISA or Master Charge

Name of Spouse or Guardian: _____ **DOB:** _____

Relationship to Patient: _____

Home Address and Phone (if different): _____

S.S. #: _____ **Occupation:** _____

Employer: _____ **Phone:** _____

Address: _____

PRIMARY INSURANCE COMPANY: _____

Individual ID #: _____ Group #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ DOB: _____

Employer: _____

SECONDARY INSURANCE COMPANY: _____

Individual ID #: _____ Group #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ DOB: _____

Employer: _____

WORKERS' COMPENSATION INSURANCE CO.: _____
(If Applicable)

Date of Injury: _____ Time of Injury: _____

Description of Accident: _____

_____

Employer of Injured: _____

Employer's Address: _____

_____ Phone: _____

Name of Supervisor: _____

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Patient Name: _____

Chart Number: _____ Date of Birth: _____

I understand that it is my responsibility to check with my insurance company to verify what my policy may or may not cover.

I accept full financial responsibility for any charges incurred today if:

1. The services rendered or supplies used/purchased are not covered under my insurance plan;
2. My insurance plan requires that I pay a deductible, co-payment, or co-insurance;
3. There are charges that have resulted because I have failed to provide current and valid insurance policy information; or
4. My insurance plan requires that I obtain a referral prior to my visit and I do not have one in place.

I agree:

1. Payment be made to The Eye Care Group, PC (TECG) by my insurance carrier for services rendered or product received;
2. TECG may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or any other third party;
3. To pay for my co-pay and other charges that are not covered by my insurance carrier today or make financial arrangements satisfactory to TECG for payment;
4. If I am not able to pay TECG for balances within 30 days, to pay a 1% interest charge, compounded, per month for my balance.
5. To pay a $15.00 service fee for any copayment not paid at the time of service.
6. To pay for any returned check fees incurred by TECG.
7. If I am the parent/guardian bringing in a child for treatment, that I am responsible for all fees incurred by the child.
8. To pay collection expenses and attorney's fees if my account is sent to the collection agency or an attorney for collection.
9. To pay for my refraction expense if my insurance does not cover.
10. Failure to make any payments for services I am responsible for may reslt in the forfeiture of scheduling future appointments.
11. Non-compliance with The Eye Care Group, PC (TECG) Financial Agreement and/or signed Payment Agreement Plans may result in a formal Patient Discharge from the Practice.

Date: _____ Signature: _____