LTAVISION
Lina T Arango / Optometric Physician

# PRE-EXAM QUESTIONNAIRE

**DATE:**_____

## INTRODUCTION

This health questionnaire is to assist us in understanding your visual and health needs.
All information provided will remain confidential.

**LAST NAME:**_____ **FIRST NAME:** _____

**CIRCLE ONE:** MR | MRS | MS | DR | MISS | MSTR **BIRTH DATE:**_____

**ADDRESS:**_____

**CITY:**_____ **POSTAL CODE:**_____

**TELEPHONE:**_____ **EMAIL:**_____

**YOU WERE REFERRED BY:**

☐ FAMILY ☐ DOCTOR ☐ WALKBY
☐ FRIEND ☐ OPHTHALMOLOGIST ☐ YELLOW PAGES
☐ INTERNET ☐ OTHER: _____

## GENERAL HEALTH HISTORY

The health of the eye is very closely related to many systemic health conditions. To help us assess your ocular health, please notify us of any existing health conditions.

**DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?**

☐ HEART TROUBLE ☐ PREGNANCY ☐ HIV+
☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ CANCER
☐ THYROID CONDITION ☐ OTHER: _____

**DO YOU HAVE ANY ALLERGIES:**
☐ **YES** ☐ **NO** IF YES, PLEASE LIST THEM:

_____

**ARE YOU TAKING ANY MEDICATIONS INCLUIDING NON-PRESCRIPTION, HERBAL OR BIRTH CONTROL PILLS?**
☐ **YES** ☐ **NO** IF YES, PLEASE LIST THEM:

_____

## EYE HEALTH HISTORY

**WHEN WAS YOUR LAST EYE EXAM?** _____

**HAVE YOU HAD ANY OF THE FOLLOWING?**

☐ SUDDEN INCREASE IN FLOATING SPOTS ☐ EYE INJURY: _____
☐ SUDDEN INCREASE IN FLASHING LIGHTS ☐ EYE SURGERY: _____
☐ FREQUENT HEADACHES ☐ OTHER: _____

**DOES ANYONE IN THE FAMILY HAVE ANY OF THE FOLLOWING?**

☐ GLAUCOMA ☐ MACULAR DEGENERATION
☐ RETINAL DETACHMENT ☐ OTHER: _____

## TODAY'S EXAM

**WHAT ARE YOUR WORK ACTIVITIES OR HOBBIES?**

**DO YOU CURRENTLY WEAR GLASSES?**
☐ **YES** ☐ **NO**
IF YES, FOR WHAT ACTIVITIES?
☐ DISTANCE (I.E. TV, DRIVING, MOVIES, SCHOOL) ☐ READING/COMPUTER USE
☐ CONSTANT USE/ ALL ACTIVITIES

**DO YOU CURRENTLY WEAR CONTACTS?**
☐ **YES** ☐ **NO**
IF YES, HOW OFTEN?_____ IF NO, WOULD YOU LIKE TO TRY? ☐ **YES** ☐ **NO**

**EYE DROPS MAY BE USED TO ASSESS THE HEALTH OF YOUR EYES. THESE DROPS MAY AFFECT YOUR VISION FOR SEVERAL HOURS AND MAY IMPAIR YOUR ABILITY TO DRIVE OR PERFORM TASKS UP CLOSE.**

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# Informed Consent for Pupil Dilation & HIPPA Privacy Form

## PUPILLARY DILATION

Our doctors use eye drops to dilate your pupils as part of a comprehensive eye evaluation. There is NO additional fee for this service. Pupil dilation allows the doctor to view key structures of the eye, to determine if you have any disease that may affect your vision including but not limited to Diabetic Retinopathy, a Retinal detachment; tumor or mass; among others.

This drops typically cause decreased reading vision and light sensitivity for about 3 hours, usually, distance vision is minimally affected.

However, if you feel uncomfortable driving or have never driven with your eyes dilated it may be best to have a driver.

_____ YES, I would like to be dilated

_____ NO, I would like to decline dilation.

I understand I am assuming all risks associated with failure to diagnose eye conditions due to lack of information, which may have be provided by this test.

Patient's Name: _____

Signature: _____

Date : _____

## HIPPA PRIVACY FORM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED IN HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At LTA VISION, we have always kept your health information secure and confidential. A new law requires us to continue those practices, to give you this notice, and to follow its terms.

We have a comprehensive Notice of Privacy Practices that describes the use and disclosure of your health information. We will not disclose your information for purposes other than for treatment including care and services provided here, and also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. You can get a copy of our privacy practices here at the office or from our web site. I have been offered a copy of the Notice of Privacy Practices and have been provided an opportunity to review it. I also understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary for treatment and to secure payment of benefits.

I authorize the use of this signature on all insurance submissions if necessary.

Patient's Name _____

Signature: _____

Date: _____