# Brain & Eye Connection Vision Clinic

Carolanne H. Roach, OD 1530 SW 89th St, Bldg D-2, OKC, OK 73159 (405) 703-3163
www.BrainAndEyeConnection.com Fax (405) 353-6718 VisionClinic@BrainAndEyeConnection.com

**PRIVACY POLICY, CONSENT TO TREAT AND FINANCIAL RESPONSIBILITY**

Patient Name: _____ Birthday: _____

**Privacy Policy**

I acknowledge that the Notice of Privacy Practices is available at www.brainandeyeconnection.com or the office location where treatment is conducted and that I have read and understood the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided. I also give permission to release protected health information to third party insurances for the purpose of processing insurance claims. I also give permission to send email and text messages for appointment reminders.

**Consent to Treat**

I authorize Brain & Eye Connection Vision Clinic, PC to treat the patient listed on this form.

**Financial Policy**

All fees including co-payment, co-insurance, deductibles, and non-covered services (including refraction - $35 charge and possible wellness screening tests - $50) are due and payable on the date of service unless other payment arrangements have been made. I understand that insurance claims are filed as a courtesy and that some testing and/or treatment procedures may not be covered by health insurance, and I will be responsible for those charges. Charges for services will be due upon receipt of a patient billing statement unless specific arrangements have been made for an extension of time. If payments cannot be made when due, please contact our office as soon as the statement is received to arrange a payment plan. Also, a $50.00 fee will be charged for patients that cancel within 48 hours or fail to show up for the scheduled appointment. There is no charge for cancelations made prior to 48 hours before appt.

I have read and understood the above statements and agree to all of the listed items:

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

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## AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name:_____ Birthday: _____ SSN:_____

**Please list all doctors, family members, or organizations you wish to have access to your records.**

| Type of Doctor/Person/Organization | Name of Doctor/Person/Organization | Relationship/Title |
|---|---|---|
| ☐ Eye Care Physician | | MD / DO / OD |
| ☐ Eye Care Physician | | MD / DO / OD |
| ☐ Family Doctor(PCP)/Pediatrician | | MD / DO |
| ☐ Other Dr. – Neuro/Cardio/Etc. | | MD / DO |
| ☐ Occupational Therapist | | |
| ☐ Physical Therapist | | |
| ☐ Speech Therapist | | |
| ☐ Psychologist/Psychiatrist/Counselor | | |
| ☐ School/Employer | | |
| ☐ Family Member/Friend | | |
| ☐ Family Member/Friend | | |
| ☐ Family Member/Friend | | |
| ☐ Other/hospital | | |

Specify type of information to be disclosed or requested:

☐ Complete Record ☐ Vision Evaluation Report
☐ Last Comprehensive Exam ☐ Vision Rehab records / Progress notes
☐ Eyeglasses/Contact Lens prescription ☐ Other (specify): _____

This authorization is valid for 12 months after date signed unless specified here: _____
and covers all treatment dates unless specified here: Treatment dates ranging from: _____ to: _____

Rights

- I understand that I do not have to sign this Authorization and treatment is not conditioned on obtaining this authorization.
- I have a right to receive a copy of this Authorization.
- I have a right to revoke this authorization at any time by submitting a signed written request. The only exception to this right is if the authorized party has already acted in reliance upon this authorization.
- I understand that if the person(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by the Privacy Rule in the Code of Federal Regulations.
- I understand that a fee may be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing to anyone other than another health care provider.

By signing below, I authorize Brain & Eye Connection Vision Clinic, PC to obtain or release protected health information as stated above.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

Brain & Eye Connection
Vision Clinic

# Adult Medical History Questionnaire

**Patient Name:** _____ **Date of Birth:** _____

**Email Address:** **Date of Appt:**

## Vision History:

**Vision problems:**

**Have you been diagnosed with any of the following?** (**Please circle all that apply.**)

| | | | |
|---|---|---|---|
| **Macular Degeneration** | **Glaucoma** | **Eye Turn/Lazy Eye** | **Retinitis Pigmentosa** |
| **Diabetic Retinopathy** | **Dry Eye** | **Corneal Disease** | **Rod/Cone Dystrophy** |
| **Retinal Detachment** | **Cataracts** | **Optic Atrophy** | **Nystagmus** |

**Other:**

**List all eye <u>surgeries/injuries/eye injections</u> in the space below:** None ☐

**Past Eye Care Provider:** **Last Visit:**

Do you wear glasses? **YES** **NO** Do you wear contact lenses? **YES** **NO**

## Medical History:

**Primary Care Provider:** **Last Visit:**

**List all general medical surgeries:** _____ None ☐

Do you have an advanced directive? **YES** **NO** If no, do you want one? **YES** **NO**

## Family Medical History:

Please check all of the conditions that are in your family medical history.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Macular Degeneration | **No one** | **Father** | **Mother** | **Brother** | **Sister** | **Son** | **Daughter** |
| Glaucoma | **No one** | **Father** | **Mother** | **Brother** | **Sister** | **Son** | **Daughter** |
| Retinal Disease | **No one** | **Father** | **Mother** | **Brother** | **Sister** | **Son** | **Daughter** |
| Other Eye Conditions | **No one** | **Father** | **Mother** | **Brother** | **Sister** | **Son** | **Daughter** |
| Diabetes | **No one** | **Father** | **Mother** | **Brother** | **Sister** | **Son** | **Daughter** |
| Heart Disease | **No one** | **Father** | **Mother** | **Brother** | **Sister** | **Son** | **Daughter** |
| High Blood Pressure | **No one** | **Father** | **Mother** | **Brother** | **Sister** | **Son** | **Daughter** |
| Stroke | **No one** | **Father** | **Mother** | **Brother** | **Sister** | **Son** | **Daughter** |
| Alzheimer's/Parkinson's | **No one** | **Father** | **Mother** | **Brother** | **Sister** | **Son** | **Daughter** |
| Cancer | **No one** | **Father** | **Mother** | **Brother** | **Sister** | **Son** | **Daughter** |

Other Family History:

| **Social History:** | | |
|---|---|---|
| Have you ever smoked? **YES NO** | How often? | Quit date: |
| Do you drink alcohol? **YES NO** | How often? | Quit date: |
| Do you use marijuana/CBD oil? **YES NO** | How often? | |
| Marital status: **Never Married Married Widowed Divorced Separated** | | |
| Residence: **house apartment independent living facility assisted living facility nursing care facility Other:** | | |
| Living with: **alone wife husband son daughter mother father Other:** | | |
| Occupation: | | **Retired Disabled** |
| Have you ever been in any car accidents? **YES NO** If so, how many? | | |
| Are you currently driving? **YES NO** If so, do you drive at night? **YES NO** | | |

**Medical History:**

**Please circle all the conditions you have or are being treated for or check None box**

| **Constitutional:** | | | **None** ☐ |
|---|---|---|---|
| **Fatigue** | **Significant weight gain** | **Decreased appetite** | **Fever** |
| **Weakness** | **Significant weight loss** | **Increased appetite** | **Chills** |

| **Neurological:** | | | **None** ☐ |
|---|---|---|---|
| **Headaches** | **Concussion** | **Tremors** | **Multiple sclerosis** |
| **Migraines** | **Balance disturbances** | **Parkinson's** | **Loss of sensation** |
| **Stroke** | **Seizures/epilepsy** | **Dementia** | **Paralysis or paresis** |
| **Mini Stroke (TIA)** | **Cognitive impairment** | **Alzheimer's** | **Cerebral palsy** |
| **Head/brain injury** | **Numbness/Neuropathy** | **Dizziness** | **Lightheadedness** |

| **Sleep conditions** | | | **None** ☐ |
|---|---|---|---|
| **Narcolepsy** | **Restless leg syndrome** | **Insomnia** | **Sleep apnea** |

| **Ears, Nose, Mouth, Throat:** | | | **None** ☐ |
|---|---|---|---|
| **Hearing loss** | **Deafness in right ear** | **Sinus condition(s)** | **Vertigo** |
| **Right hearing aid** | **Deafness in left ear** | **Seasonal allergies** | **Tinnitus** |
| **Left hearing aid** | **Deafness in both ears** | **Chronic allergies** | **Dentures** |
| **R&L hearing aids** | **Usher's Syndrome** | **Chronic ear infections** | **Dry mouth** |

| **Cardiovascular:** | | | **None** ☐ |
|---|---|---|---|
| **History of heart attack** | **Pacemaker** | **Congestive heart failure** | |
| **High blood pressure** | **Arrhythmia** | **Coronary artery disease** | |
| **High cholesterol** | **Valve disease** | **Peripheral artery disease** | |

| **Respiratory:** | | | **None** ☐ |
|---|---|---|---|
| **Asthma** | **COPD/emphysema** | **Pneumonia** | **Chronic lung disease** |
| **Tuberculosis** | **Shortness of breath** | **Sarcoidosis** | **Chronic bronchitis** |

| **Gastrointestinal:** | | | **None** ☐ |
|---|---|---|---|
| **Heartburn/reflux** | **Gall bladder disease** | **Stomach ulcers** | **Hepatitis A** |
| **Abdominal pain** | **Diverticulitis** | **Constipation** | **Hepatitis B** |
| **Chron's disease** | **Irritable bowel disease** | **Liver disease** | **Hepatitis C** |

| **Genitourinary:** | | | **None** ☐ |
|---|---|---|---|
| **Incontinence** | **Frequent urination** | **Kidney failure** | **Dialysis** |
| **HIV/AIDS** | **Sexually transmitted disease:** | | |
| **Men:** Enlarged prostate | with difficult urination | **Women:** Post-menopausal | |

| **Skin:** | | | **None** ☐ |
|---|---|---|---|
| **Psoriasis** | **Skin rash** | **Albinism** | **Rosacea** |
| **Eczema** | **Skin bumps/lumps** | **Dry skin** | **Itching** |

| **Musculoskeletal:** | | | **None** ☐ |
|---|---|---|---|
| **Arthritis** | **Rheumatoid arthritis** | **Myasthenia gravis** | **Osteoporosis** |
| **Joint pain** | **Stiffness or limited range** | **Muscular dystrophy** | **Fibromyalgia** |
| **Muscle pain** | **Ankylosing spondylitis** | **Limb amputation** | **Gout** |

| **Hematologic/Lymphatic:** | | | **None** ☐ |
|---|---|---|---|
| **On blood thinner** | **Easily bruised** | **Anemia** | **Lyme disease** |
| **Clotting difficulties** | **Edema/swelling** | **Sickle cell** | **Blood disorder** |

| **Psychiatric:** | | | **None** ☐ |
|---|---|---|---|
| **Depression** | **ADD** | **Panic episodes** | **Developmental delay** |
| **Anxiety** | **ADHD** | **PsuedoBulbar affect (PBA)** | **Asperger's Syndrome** |
| **Bipolar** | **Autism** | **Obsessive compulsive (OCD)** | **PTSD** |

| **Autoimmune/Genetic:** | | | **None** ☐ |
|---|---|---|---|
| **Sjogren's Syndrome** | **Lupus** | **Giant Cell Arteritis** | **Down's Syndrome** |

| **Cancer: (Please circle all that apply** | | | **None** ☐ |
|---|---|---|---|
| **Breast cancer** | **Neurofibromatosis** | **Melanoma** | **Colon cancer** |
| **Prostate cancer** | **Non-cancerous tumors** | **Leukemia** | **Lung cancer** |
| **Brain cancer** | **Basal cell carcinoma** | **Liver cancer** | **Thyroid cancer** |
| **Retinoblastoma** | **Squamous cell carcinoma** | **Kidney cancer** | **Lymphoma** |
| **Other:** | | | |

| **Endocrine:** | | | **None** ☐ |
|---|---|---|---|
| **Hypothyroidism** | **Graves's disease** | **Heat intolerance** | **Pituitary condition** |
| **Hyperthyroidism** | **Hormonal changes** | **Cold intolerance** | **Adrenal condition** |
| **Diabetes – Type 1 Type 2** | | **Duration:** _____ | **years** |
| **Last fasting blood sugar:** | | **Last HbA1c:** | |

**Other conditions not listed above?**

| Prescription/Vitamins/OTC & Purpose of Med | mg | AM | Noon | PM | Bed |
|---|---|---|---|---|---|
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**No Medications/Vitamins Taken** ☐

| Name of Eye Drops (Rx and OTC) None ☐ | Which eye(s)? | How often? |
|---|---|---|
| | left right both | |
| | left right both | |
| | left right both | |
| | left right both | |
| | left right both | |

| Drug Allergies/Reaction to Drug | No known drug allergies ☐ |
|---|---|
| / | / |
| / | / |
| / | / |
| / | / |

Brain & Eye Connection
Vision Clinic

# Brain Injury History Questionnaire

**Patient Name:** _____ **Date of Birth:** _____

**Form filled in by:** **Date of Appt:**

## Brain Injury History: (circle all the types of injuries that you have had.

| | | |
|---|---|---|
| Stroke (from blood clot) | Brain bleeding | Motor vehicle accident |
| Stroke (from brain bleeding) | Brain surgery | Brain cancer/tumor(s) |
| Stroke (unknown reason) | Whiplash | Medication/drug-related |
| Surgery related brain damage | Lack of Oxygen | IED/Blast related damage |
| Head injury due to a fall | Aneurysm | Concussion |

**Head trauma – Describe trauma:** _____

**Other:**

## What part of your head/brain was affected: (Circle all that apply)

| | | | | |
|---|---|---|---|---|
| Forehead | Top of head/brain | Right side | Frontal lobe | Temporal lobe |
| Face | Back of head/brain | Left side | Parietal lobe | Occipital lobe |

**Other:**

## Brain Injury Timeline: (list the date and type of injury you had – use the last page for more info)

**Date:** _____ **Injury:** _____

**Date:** _____ **Injury:** _____

**Date:** _____ **Injury:** _____

**Date:** **Injury:**

## Headache History:

**Have you noticed significant headaches after the brain injury/stroke?** YES NO

**Did you have these types of headaches before the brain injury/stroke?** YES NO

**Where are the headaches located: (Circle all that apply)**

| | | | | |
|---|---|---|---|---|
| Forehead | Top of head/brain | Right side | Beneath cheeks | Back of neck |
| Temples | Back of head/brain | Left side | Around/behind eyes | Shoulders |

**Other:**

**Describe the headaches and what relieves them:** _____

## Care Team: (please list the doctors/therapists you have seen or are seeing)

| Name of Professional Seen | Care Ongoing? | | Date of Last Visit? |
|---|---|---|---|
| Neurologist: _____ | YES | NO | |
| Neurosurgeon: _____ | YES | NO | |
| Physiatrist: _____ | YES | NO | |
| Cardiologist: _____ | YES | NO | |
| Psychologist/Psychiatrist: _____ | YES | NO | |
| Physical Therapist: _____ | YES | NO | |
| Occupational Therapist: _____ | YES | NO | |
| Speech Therapist: _____ | YES | NO | |
| Rehab Facility: | YES | NO | |

| Symptoms Following Injury: (please rank your symptoms after your injury) | | | | | |
|---|---|---|---|---|---|
| **Symptoms** | **Never 0%** | **Seldom 1-25%** | **Occasionally 26-50%** | **Frequently 51-75%** | **Always 76-100%** |
| Distance vision blurry (even w/ glasses) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Near vision blurry (even w/ glasses) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Clarity of vision fluctuates during the day | ☐ | ☐ | ☐ | ☐ | ☐ |
| Poor night vision/can't see to drive at night | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eye discomfort/sore eyes/eyestrain/eye pain | ☐ | ☐ | ☐ | ☐ | ☐ |
| Headaches after using eyes/reading/near work/etc. | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eye fatigue/very tired after using eyes all day | ☐ | ☐ | ☐ | ☐ | ☐ |
| Double vision (constant or when tired) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Feel "pulling"/strain around the eyes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Close one eye to see more clearly/less strain | ☐ | ☐ | ☐ | ☐ | ☐ |
| Difficulty focusing/words move on the page | ☐ | ☐ | ☐ | ☐ | ☐ |
| Short attention/easily distracted when reading | ☐ | ☐ | ☐ | ☐ | ☐ |
| Skipping/repeating lines/words when reading | ☐ | ☐ | ☐ | ☐ | ☐ |
| Loss of place when reading/need place holder | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lower comprehension with reading | ☐ | ☐ | ☐ | ☐ | ☐ |
| Slower reading speed/lower stamina to read | ☐ | ☐ | ☐ | ☐ | ☐ |
| Decline in handwriting (spacing/size/legibility) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Over/under reach for objects (misjudge distance) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Changes in balance/gait/going up or down stairs | ☐ | ☐ | ☐ | ☐ | ☐ |
| Restricted field of view/missing objects | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tendency to lean to/run into objects on one side | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tendency to veer to one side when walking/driving | ☐ | ☐ | ☐ | ☐ | ☐ |
| Feel like the floor is not level/flat when walking | ☐ | ☐ | ☐ | ☐ | ☐ |
| Difficulty in visually busy places (i.e. grocery store) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Nausea/discomfort while watching moving objects | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stationary objects tend appear moving but aren't | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dizziness/vertigo/disorientation | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arm-hand/leg-foot weakness on one side | ☐ | ☐ | ☐ | ☐ | ☐ |
| Difficulty with speech/forming words | ☐ | ☐ | ☐ | ☐ | ☐ |
| Indoor lighting is bothersome/too much glare | ☐ | ☐ | ☐ | ☐ | ☐ |
| Indoor fluorescent lighting is bothersome | ☐ | ☐ | ☐ | ☐ | ☐ |
| Outdoor lighting is usually bothersome | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eyes feel "dry" and sting/burn | ☐ | ☐ | ☐ | ☐ | ☐ |
| Frequent eye rubbing/blinking to clear vision | ☐ | ☐ | ☐ | ☐ | ☐ |
| Difficulty recognizing familiar faces/places/words | ☐ | ☐ | ☐ | ☐ | ☐ |
| Difficulty with memory/names/events/etc. | ☐ | ☐ | ☐ | ☐ | ☐ |
| **For office use only Total ____** | ___ | ___ | ___ | ___ | ___ |

| Additional comments: (describe any additional information about your injury/stroke/surgery/etc. here) |
|---|
| |
| |
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| |
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| |