Welcome to The FOCUS Center

Sarah E. Lane, O.D.

NJ Lic# 6103

Medical History Questionnaire

Mr., Mrs., Ms., Miss, Dr. ____________________________ Sex:___ Marital Status:________ Today's Date:______________
Address:____ Birthdate:__________________ Age:______________________
City / State / Zip:________________________________ SSN:____
Home phone:______________________________________ Eye Care Insurance Carrier:_____________________________
Responsible party:_________________________________ Insurance ID number:_________________________________
Address if different:_______________________________ Work Phone:_______________________________________
Is this your first visit to our office?___________________ Employer:____
Recommended by:__________________________________ Occupation:_______________________________________
When was your last eye exam?______________Doctor:______________Location:________________________________
Have you ever worn glasses?_______________For: Distance Near Computer (circle all that apply)
Have you ever had vision training or vision rehabilitation □ no □ yes If yes how long ago?______________________________
Reason for today's visit: ____
____
Are there times when your vision or glasses do not work well for you?____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections, eye surgery or eye injury:____
____
Do you have any **medication allergies**? □ no □ yes If yes please explain:____
____
Do you have any other allergies? □ no □ yes If yes please explain:____
____
Please list **all medications** you use (including oral contraceptives, aspirin, over the counter medications, vitamins, supplements and home remedies):__
____
____
Who is your **primary care physician**?_____________________________Approximate date of last exam:___________________
Are you being **treated or monitored** for any medical condition(s)?:Please describe____
____
Have you ever experienced a head injury, whip lash injury or concussion? □ no □ yes If yes, please provide date, nature of the injury and visual problems that may be related:____
____
Are you **pregnant or nursing**? □ no □ yes If yes include due date or date you gave birth:_______________________________

Contact Lens History

I am interested in contact lenses as a new wearer □

I currently wear contact lenses and would like them updated □
Brand/type:__________________________________
How often do you change them?______________
Problems or concerns:_______________________

I have worn contact lenses in the past □
Brand/ type:__________________________________
How long ago?________________________________

Glasses Interests and Needs

Please list activities for which you require glasses: please include sports and recreational activities, hobbies and occupational related tasks: _______
____
Do you use a computer? □ no □ yes If yes, how many hours per day?____

Are you interested in information concerning Laser Vision Correction (Lasik, etc)? □ yes □ no

Social History

This information is kept strictly confidential, However, you may discuss this portion directly with the doctor if your prefer.

Do you drive? □ no □ yes
If yes, do you have any visual difficulty when driving? □ no □ yes
If yes, please describe:____
Do you use tobacco/cigarettes? □ no □ yes If yes, type/amount/how long:____
Do you drink alcohol? □ no □ yes If yes, type/amount/how long/how often:______________________________________
Do you use illegal or recreational drugs? □ no □ yes If yes, type/amount/how long:________________________________
Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

** a copy of our privacy policy is available to you upon request **

Family History

Please note any family history (parents, grandparents, siblings, children; (living or deceased)) for the following conditions:

Disease/ condition	No	Yes	?	Relationship to you
Asthma	☐	☐	☐	______________
Blindness	☐	☐	☐	______________
Cataract	☐	☐	☐	______________
Crossed Eyes	☐	☐	☐	______________
Glaucoma	☐	☐	☐	______________
Macular degeneration	☐	☐	☐	______________
Retinal detachment/ Disease	☐	☐	☐	______________
Arthritis	☐	☐	☐	______________
Cancer (specify type)	☐	☐	☐	______________
Diabetes	☐	☐	☐	______________
Heart Disease	☐	☐	☐	______________
High Blood Pressure	☐	☐	☐	______________
Kidney Disease	☐	☐	☐	______________
Lupus	☐	☐	☐	______________
Thyroid Disease	☐	☐	☐	______________

Review of Systems

Do you currently, or have you ever had any of the problems in the following areas:

System	No	Yes	?
CONSTITUTIONAL			
Fever, weight loss/gain	☐	☐	☐
INTEGUMENTARY (SKIN)			
Psoriasis	☐	☐	☐
Acne Rosacea	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of vision	☐	☐	☐
Blurred vision	☐	☐	☐
Distorted vision	☐	☐	☐
Loss of side vision	☐	☐	☐
Double Vision	☐	☐	☐
Tired eyes	☐	☐	☐
Eye Strain	☐	☐	☐
Dryness	☐	☐	☐
Mucous discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or gritty feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign body sensation	☐	☐	☐
Excessive tearing/ watering	☐	☐	☐
Glare/ light sensitivity	☐	☐	☐
Eye pain or soreness	☐	☐	☐
Chronic infection of Eye/ Lid	☐	☐	☐
Sty or Chalazion	☐	☐	☐
Flashes or floaters	☐	☐	☐
ENDOCRINE			
Thyroid Gland	☐	☐	☐
Pituitary Gland	☐	☐	☐
Diabetes	☐	☐	☐

	No	Yes	?
EAR, NOSE, MOUTH, THROAT			
Allergies/ hay fever	☐	☐	☐
Sinus congestion	☐	☐	☐
Runny nose	☐	☐	☐
Post nasal drip	☐	☐	☐
Chronic cough	☐	☐	☐
Dry mouth/ throat	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Heart pain	☐	☐	☐
High Blood pressure	☐	☐	☐
Vascular disease	☐	☐	☐
Heart attack or stroke	☐	☐	☐
GENITOURINARY			
Genitals/ Kidney/ Bladder	☐	☐	☐
Reproductive system	☐	☐	☐
Prostate (men)	☐	☐	☐
GASTROINTESTINAL			
Chronic diarrhea or constipation	☐	☐	☐
BONE / JOINTS			
Rheumatoid Arthritis	☐	☐	☐
Muscle pain	☐	☐	☐
Joint pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding problems	☐	☐	☐
Hepatitis	☐	☐	☐
HIV	☐	☐	☐
Cancer	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC			
Depression	☐	☐	☐
Anxiety	☐	☐	☐

If you answered yes to any of the above, please explain:______________________________

____

Patient signature:______________ **Doctor's signature:**______________ **Date:**__________

Changes:______________________ **Date:**__________ **Px:**__________ **Doc:**__________

Changes:______________________ **Date:**__________ **Px:**__________ **Doc:**__________

Welcome to FOCUS Center for Vision and Learning, LLC

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NJ Lic# 6103

Convergence Insufficiency Symptom Survey (CISS)

Please ask these questions of your child and fill in the appropriate boxes with an ✕ indicting the frequency of each symptom.

Possible Subjective Symptom	Never	Infrequently/ Not often	Sometimes	Fairly Often	Always
1. Do your eyes feel tired when reading or doing close work?					
2. Do your eyes feel uncomfortable when reading or doing close work?					
3. Do you have headaches when reading or doing close work?					
4. Do you feel sleepy when reading or doing close work?					
5. Do you lose concentration when reading or doing close work?					
6. Do you have trouble remembering what you have read?					
7. Do you have double vision when reading or doing close work?					
8. Do you see the words move, jump, swim or appear to float on the page when reading or doing close work?					
9. Do you feel like you read slowly?					
10. Do your eyes ever hurt when reading or doing close work?					
11. Do your eyes ever feel sore when reading or doing close work?					
12. Do you feel a “pulling” feeling around your eyes when reading or doing close work?					
13. Do you notice the words blurring or coming in and out of focus when reading or doing close work?					
14. Do you lose your place while reading or doing close work?					

Total score: (to be completed by the doctor)________________

Notes:____

____

Reference:Borsting EJ, Rouse MW, Mitchell GL, et al and the SITT group. Validity and reliability of the revised convergence insufficiency symptom survey in children. Optometry and Vision Science 2003; 80(12):832-838

Dr. Sarah Lade, OD

Focus Center for Vision and Learning

HIPAA Release Form

This form gives Dr. Lane permission to discuss the patient's evaluation findings, therapy notes and progress and diagnosis with other teachers, therapists and healthcare providers. A printed report of Dr. Lane's findings will be provided to the patient/guardian. The patient or guardian is responsible for providing copies of the report to 3rd parties.

Patient Name: ________________________ Date of Birth: _____/____/_____

Parent/Guardian Name:_______________________________

Release of Information

[ ] I authorize the release of information including the examination findings, diagnosis, records, and therapy notes/progress regarding ________________ at Focus Center for Vision and Learning.
This information may be released to:
[ ] Teachers: ____
[ ] Therapists:____
[ ] Doctors: ____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Signature:________________________ Date:___________________________