

**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 are 60 or older and have had sudden visual loss, please answer the following questions:

- 1. Was the visual loss gradual or sudden? \_\_\_\_\_
- 2. Are you having any of the following?:
  - a. Scalp or temple tenderness?  Yes  No
  - b. Pain in your tongue, gums, or jaw?  Yes  No
  - c. New pain in your shoulders or thighs?  Yes  No
  - d. Weight loss, fever, loss of appetite, general sense of malaise or fatigue?  
 Yes  No

11. Did you start any medications at about the time your visual symptoms began?  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. Are you aware of blurred vision or difficulty seeing to either side?  Yes  No

11. Are you taking any new medication?  Yes  No

12. 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. \_\_\_\_\_

\_\_\_\_\_

**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)**

1. Please list all the **MEDICATIONS** you are taking. (Please bring all your medications with you). Include any herbal products, over-the-counter medications, and vitamins. Also please indicate if you take Viagra or any other similar medication.

<u>NAME OF DRUG / DROP</u>	<u>DOSE</u>	<u>FREQUENCY</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Please list all **ALLERGIES** to medications.

_____	_____	_____
_____	_____	_____

3. **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		

If yes, when diagnosed: \_\_\_\_\_

Any Other Information About Medical History Not Included?: \_\_\_ YES \_\_\_ NO

**4. REVIEW OF SYSTEMS Do you currently have any problems in the following areas?**

**EAR, NOSE, MOUTH, THROAT**

Difficulty Hearing  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

Venereal Disease  YES  NO

Sexually Transmitted Disease  YES  NO

**NEUROLOGICAL**

Seizures  YES  NO

Migraine  YES  NO

Headaches  YES  NO

Stroke  YES  NO

Weakness of Arms/Legs  YES  NO

**DRUG USE**

YES  NO

**RESPIRATORY**

Chronic Cough  YES  NO

Shortness of Breath  YES  NO

Sleep Apnea  YES  NO

**MUSCULOSKELETAL**

Muscle Pain  YES  NO

Joint Pain  YES  NO

**EYES**

See Past Eye History

**SKIN**

Rash  YES  NO

**PSYCHIATRIC**

Depression  YES  NO

Anxiety  YES  NO

**ENDOCRINE**

Excessive Thirst  YES  NO

Heat Intolerance  YES  NO

Dizziness  YES  NO

Difficulty Swallowing  YES  NO

Speech Problems  YES  NO

Carotid Artery Surgery  YES  NO

Numbness  YES  NO

**AIDS / HIV**

YES  NO

**HEMATOLOGICAL / LYMPHATIC**

Anemia  YES  NO

Other \_\_\_\_\_

**CONSTITUTIONAL SYMPTOMS**

Fever  YES  NO

Weight Loss  YES  NO

Fatigue  YES  NO

Do you have any medical problems or symptoms we have not asked about?  Yes  No

If "Yes", please provide information. \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

6. Have you had any **INJURIES** or been in any **AUTOMOBILE ACCIDENTS**?  Yes  No  
If yes, please describe. \_\_\_\_\_

7. **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 \_\_\_\_\_ YES \_\_\_\_\_ NO
  - (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 ? \_\_\_\_\_

8. **SOCIAL HISTORY:**

Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
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 \_\_\_\_\_  
History of alcohol abuse?  Yes  No  
More than three drinks per day?  Yes  No  
Have you ever been a heavy drinker?  Yes  No  
If so, when did you stop? \_\_\_\_\_

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

**9. FAMILY HISTORY:**      **AGE**                              **HEALTH**                              **ILLNESSES**

Mother: \_\_\_\_\_

\_\_\_\_\_

Father: \_\_\_\_\_

\_\_\_\_\_

Brothers / Sisters: \_\_\_\_\_

\_\_\_\_\_

Children: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Family Members: \_\_\_\_\_

\_\_\_\_\_

Is there any family history of neurologic or eye disease other than needing to wear glasses?

Yes     No \_\_\_\_\_

10. Is there any other aspect of your **MEDICAL HISTORY** that you have not included?

Yes     No \_\_\_\_\_





**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. #:** \_\_\_\_\_

**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?

\_\_\_\_ **Doctor:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_ **Friend/Relative:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_ **Other:** \_\_\_\_\_

**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 copay 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 for any returned check fees incurred by TECG.
6. If I am the parent/guardian bringing in a child for treatment, that I am responsible for all fees incurred by the child.
7. To pay collection expenses and attorney's fees if my account is sent to the collection agency or an attorney for collection.
8. To pay for my refraction expense if my insurance does not cover.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_