

GENERAL HISTORY

DATE _____

PATIENT NAME: MR. MRS. MS. _____

RESPONSIBLE PARTY: _____ SS# _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____

OCCUPATION: _____ EMPLOYED BY: _____

DATE OF BIRTH: _____ AGE: _____ REFERRED BY: _____

FAMILY PHYSICIAN: _____ AGE OF PRESENT GLASSES: _____

LAST EYE EXAM DATE: _____ FROM DR: _____

WHAT BRINGS YOU TO OUR OFFICE TODAY? _____

HAVE YOU EVER BEEN TO SEE DR. GUBANY/ DR. PASIERB IN THIS OFFICE BEFORE? _____

ARE YOU ALLERGIC TO ANYTHING? _____

DO YOU OR ANY BLOOD RELATIVE HAVE LAZY EYE? WHO? _____

DO YOU HAVE FREQUENT HEADACHES? _____

WHEN, WHERE, HOW OFTEN? _____

DOES SUNLIGHT OR BRIGHT LIGHTS BOTHER YOU? _____

DO YOU EVER SEE DOUBLE? WHEN? _____

DO YOU HAVE TROUBLE WITH NIGHT VISION? _____

HAVE YOU EVER HAD ANY EYE INFECTION, SURGERY, OR INJURY? _____

DO YOU HAVE COLOR VISION PROBLEMS? _____

HAVE YOU EVER WORN CONTACT LENSES? _____ DO YOU NOW WEAR CONTACT LENSES? _____

HOW LONG HAVE YOU HAD THEM? _____ ARE THEY COMFORTABLE? _____

HAVE YOU WORN THEM BEFORE AND QUIT? WHY? _____

ARE THEY COMFORTABLE ALL DAY? _____ HOURS WORN BEFORE DISCOMFORT BEGINS _____

TYPE OF LENSES WORN _____ CONTACTS FIT BY DR. _____

DO YOU USE LUBRICATING EYE DROPS ? WHAT BRAND ? _____

HAVE YOU OR A BLOOD RELATIVE EVER HAD (CIRCLE) :

DRY EYE SYNDROME (K. SICCA) BLEPHARITIS GLAUCOMA TUBERCULOSIS LUPUS
GOUT CATARACTS ARTHRITIS DIABETES THYROID DISORDER HEART DISEASE
HIGH BLOOD PRESSURE SJOGRENS SYNDROME SYSTEMIC SCLEROSIS TRACHOMA
POLY MYOSITIS PRIMARY BILIARY CIRRHOSIS BELL'S PALSY DIABETIC RETINOPATHY
JUVENILE RHUMATOID ARTHRITIS STEVEN'S JOHNSON SYNDROME ARCUS
HYPOVITAMINOSIS A (XEROPHTHALMIA) IRRADIATION EYE DAMAGE
CICATRICAL OCULAR PEMPHIGOID CHEMICAL BURNS TO THE EYE
AGE RELATED MACULAR DEGENERATION

DO YOU OR ANY BLOOD RELATIVE HAVE ANY OTHER EYE DISEASE THE DOCTOR SHOULD KNOW ABOUT? _____

DO YOU TAKE ANY OF THE FOLLOWING MEDICATION?

DECONGESTANTS ANTIHISTAMINES DIURETICS HEART DISEASE MEDICATIONS
ULCER PRESCRIPTIONS ANTIDEPRESSANTS ANESTHETICS BETA BLOCKERS
HORMONE SUPPLEMENTS BIRTH CONTROL HI-DOSE VITAMINS
ASPIRIN REGULARLY ACNE MEDICATION

PLEASE LIST ALL MEDICATIONS BOTH OVER THE COUNTER AND PRESCRIPTION THAT YOU ARE CURRENTLY USING AND THE AILMENT THAT IT IS TREATING _____

DO YOU CURRENTLY USE TOBACCO OR ALCOHOL? _____
HAVE YOU BEEN TREATED FOR SUBSTANCE ABUSE? _____ WHEN? _____

HOW DID YOU FIND OUT ABOUT EYECARE WASHINGTON, DR. GUBANY, DR. PASIERB?

NEWSPAPER TV RADIO REFERRAL FRIEND PHONE BOOK DIRECT MAIL
OTHER (PLEASE SPECIFY) _____

PAYMENT EXPECTED ON DAY OF VISIT, WE HAVE NO BILLING SYSTEM

I HAVE RECEIVED A COPY OF THE EYECARE WASHINGTON PRIVACY POLICY
SIGNATURE _____ DATE _____

QuantifEYE™

Qualitative Understanding and Nutritional Treatment Intervention for the EYE

\$25.⁰⁰

To Our Patients

We continuously strive to provide our patients the very best in eye care services. Recently, we acquired a device that allows us to assess your risk of developing an eye disease called Macular Degeneration. This disease is a leading cause of blindness in adults and there is no adequate treatment; however, it can be managed if caught early. We can now take measures to reduce your risk of developing this disease. The test is a light response test that only takes a few minutes.

Risk Factors *(please check if any of the following apply to you)*

- Age: over 60
- Family History *(please check all that apply):*
 - Macular Degeneration, Glaucoma, Cataract, High Blood Pressure, Diabetes, Heart Disease
- I have *(please check all that apply):*
 - Macular Degeneration, Glaucoma, Cataract, High Blood Pressure, Diabetes, Heart Disease
- Female
- Light Eyes, Light Skin
- Sensitive to Light
- Excessive exposure to sun
- Smoker (check even if you have quit)
- Inadequate consumption of green, leafy vegetables

We strongly recommend that you take this test, so we can determine your risk for Macular Degeneration and develop a base-line measurement that allows us to track any changes that might occur in the future. Since this is a new test, never before available, it is not covered by your insurance; however, the cost to you is minimal.

Should you have any questions, please do not hesitate to ask.

I understand my risk factors for Macular Degeneration and choose to:

- ACCEPT TEST
- DECLINE TEST

Patient Signature

Date

For Office Use

Risk Assessment:

Doctor's Risk Determination

<i>(circle one)</i>	High	Med	Low
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MPOD Score _____ R/L
<.25 .25 - .45 >.45
Lower Mid Range Higher
Range Range Range