Nutritional Optometry Associates
16 North Beverwyck Road, P.O. Box 131, Lake Hiawatha, NJ 07034-0131—**www.NutriOptom.com**
425 Madison Avenue at 49th Street——Suite 802, New York, NY 10017-1128, USA--**(212) 759-5270**

Director: Benjamin C. Lane, O.D., M.P.H., F.A.A.O., F.C.O.V.D., *Optometric Physician,* www.NutriOptom.com
Tel.: (973) 335-0111; FAX: (973) 335-2882 or 541-1649; E-Mail: Dr.Lane@NutriOptom.com

"In The Vanguard Of Dietary Research And Integrative Therapy In The Prevention And Reversal Of Eye & Vision Disorders"

PATIENT QUESTIONNAIRE **DATE: ____/____/____**

NAME: Ms, Mrs Mr _____ **SS#:** _____

ADDRESS (Res): _____ **Medicare#:** _____

City _____ **State** _____ **Zip** _____ **BIRTHDATE:** _____

PHONES: Res ( ) - _____ **Cell ( ) -** _____ **AGE:** _____ **yrs** _____ **months**

FAX ( ) - _____ **HEIGHT:** _____ **ft** _____ **inches; WEIGHT:** _____ **lbs**

OCCUPATION: _____ **EMPLOYER:** _____

Nutritional Optometry Associates pledge to respect your privacy in accordance with HIPAA. All third-party payors, laboratories, and health providers are required by law to protect your privacy.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any optometric or other information necessary to process any insurance or Medicare claim and as necessary to provide appropriate treatment. I also request payment of any benefits to myself or to the party who accepts assignment.

8) SIGNED_____ DATE _____/_____/_____

2nd ADDRESS: _____ **State** _____ **Zip** _____ **---** _____ **.**

11) Is this second address ( )Business? ( )Vacation? ( )Summer? ( )Winter? ( )Relative? ( )Preferred as mailing address?

OTHER PHONES AT WHICH TO REACH PATIENT—Identify as to whether work#, 2nd address, spouse, FAX, paging #:

12) **( ) -** _____

13**) ( ) -** _____ **E-Mail:** _____ @ _____

Person responsible for payment—name & relationship (self? parent? spouse?) & address including ZIP & phone:

14) _____

PRINCIPAL DOCTORS CONSULTED Address Specialty Approx dates Diagnoses

15) _____

16) _____

List may be continued on bottom of last side!

17) **REFERRED BY:** _____ **Address** _____

Accounts are paid at the time our services are provided.

18) **This account will be paid by CASH ( ) CHECK ( ) DISCOVER ( ) MASTERCARD or VISA ( ) AMEX( ) DEBIT ( ) INSURANCE ( )**

VISION HISTORY

19) What is your visual problem or in what way are your eyes troubling you?_____

20) _____

21) _____

22) Do you wear glasses now? ( )No ( )Yes ( )Bifocals ( )Trifocals ( )Progressive Adds ( )Sunglasses ( )Occupational ( )Low Vision

23) ( )Constant ( )Only for Distance ( )Only for Reading ( )For Most Closework ( )Over Contact Lenses

24) How long ago were the prescriptions changed? _____ By which Dr's Rx? _____

PLEASE CONTINUE

25) On the average, how much time do you spend at closework at work?_____ at home?_____ on weekends?_____

26) Your average reading/working distances from the eyes in inches or feet?_____

27)Time spent at computer monitor?_____ Distance from screen?_____Wearing ( )Distance Rx ( )Intermediate ( )Near ( ) Bif
28) ( )Other_____ Hours per day wearing Contact Lenses?_____ Do you have spare glasses in a current Rx? ( )No ( )Yes
29) _____

30) Does being out on a bright sunny day make your eyes feel uncomfortable?( )No ( )Sometimes ( )Somewhat ( )Very Uncomfortable
Are your eyes more uncomfortable when skies are hazy-bright? ( )No ( )Yes Duration of glare hypersensitivity: ( )None ( )Less than 15 minutes ( )As much as or more than 15 minutes. ( )Mostly only when tired ( )Most days ( ) Glare Discomfort experienced even when unshielded fluorescent ceiling expanses as in supermarkets. ( )People say I keep my home too dark—I'm uncomfortable with normal bright residential lighting. ( )Oncoming headlights bother me more than average people
34b) *Brief history of your FLOATERS:*
35) *HEADACHES:* ( )None ( )At least once/week ( )Other _____.
When? (Time of day and/or associated with what activity?)_____ Where? (Low forehead? Inside eyes? Temples at sides of head? Back of head (occiput)? Or Other locations in head?) _____
_____.

36) How relieved?_____ Do you awaken with a headache? ( )No ( )Yes
37) ***SIDE-VISION CONSTRICTION:*** ( )No ( )Yes, as follows: _____
38) ***EYE HEALTH HISTORY:*** Do your eyes often feel dry? ( )No ( )Yes Does mucus collect in eye? ( )No ( )Yes
30) History of parents, grandparents, siblings, own children with possible inherited eye disorders and your own disorders:

SPECIFIC EYE DISORDERS	**AFFECTED RELATIVE**	**DATES YOU WERE FIRST AFFECTED/TREATED**	
40) **Cataract: Type:**		**(R)**	**(L)**
41) **Glaucoma: Type:**		**(R)**	**(L)**
42) Macular Degeneration:			
Type:		**(R)**	**(L)**
43) **Eye Surgeries & Other:**		**(R)**	**(L)**

FOR STUDENTS:
44) **SCHOOL** _____ **Grade**_____
45) How are you doing in school work?_____ Do you consider yourself to be a good student? ( )No ( )Yes
46) Are you reading up to grade level? ( )No ( )Yes ( )Fast ( )Medium ( )Slow. Favorite subjects in school?_____
47) Least-liked subjects in school? _____. Number ____child of _____children in family.

48) ***HEALTH HISTORY:*** Any health problems at present? Yes_____ no____. Problem(s): _____
49) Taking **medication?** Yes___ no___. State medication(s) and what taken for
_____
50) _____.

51) Thyroid Rx? Yes_____ no_____ Date of last blood test? _____.
52) Stomach nausea or vomiting? Yes_____ no_____.
53) **Car sickness?** Yes_____ no_____. Date of last hair mineral analysis? _____.
54) Injuries to head or eyes -- severe blows? Yes_____ no_____.
55) Any pains in eyes? Yes _____ no_____.
56) Do you see haloes or rainbow colors around lights? Yes_____ no_____.
57) Blood pressure Control history: _____
_____
58) Any history of diabetes? Yes_____ no_____. Highest fasting blood sugar, if known _____
_____
59) Sinusitis? Yes_____ no_____ .

60) ***DENTAL HISTORY:*** Last dental care _____. Last X-ray _____.
61) Any impacted wisdom teeth? Yes_____ no_____. Any abscessed teeth? Yes_____ no_____.

62) ***DOMINANT:*** 1. Hand_____ 2. Foot_____ 3. Eye_____ Dist._____ Near_____ .

PLEASE CHECK: Sports, special activities or interests that are important to you.

63) Reading [hours per day:] _____ . Crafts of any kind [please list:]_____ .
64) Card Playing [which games?] _____ . Golf _____ .

65) Musical Instrument [which?] _____. Fishing _____.
66) Sewing {Other needlework?] _____ . Outdoor Activities _____.

67) Knitting _____ . Hunting or Shooting _____ .
68) Television _____ [reclined?] _____ .Desk Work _____ .

69) Reading in Bed _____ . Driving Day _____ Night _____ 70) Home workshop _____ . Other Work

PLEASE CONTINUE

:

71) _____

72) Briefly in your own words - just why are you having an examination at this time? What do you expect or want the Doctor to help73) you with ?_____

74) _____

75) _____

76) Do you or did you smoke? If so, what, how much, between what years? _____

Are you on a special diet? If so, please describe. Also, please **list** any **vitamin, mineral, glandular, or herbal supplements** you may be taking._____

(77)_____

78) _____

79) _____

80) _____

81) Are you on an exercise or activity program? Please describe. _____ .

82) _____.

83) How often do you eat tuna fish? _____ Other fish? _____.

84) Name most frequently eaten finfish & shellfish: _____.

85) Allergies: Describe as none, slight, moderate, or severe, Allergies to the following:

85a) Seasonal respiratory allergies? To what? And when? _____.

85b) Year-round respiratory allergies? To dust? To animals? _____.

85c) Food allergies? What foods? How severe? When tested? _____.

85d) Allergies to medications? Which? How severe? How long ago? _____.

86) *INSURANCE AND MEDICARE INFORMATION :*

***86a)** *Name of person holding **PRIMARY** policy if other than patient:*_____.

*86b) ***Birth date of person in (86a): / / 19 .***

***86c)** *Address of person in (86a) if different than patient's:* _____

_____.

86d) *The person in (86a) is [encircle one] the Spouse? Father? Mother? Son? Daughter? Brother? Sister? Or* _____ *of the patient?*

86e ***Policyholder's I.D. Number:*** _____. ***Group #:*** _____.

86f)** ***Name of PRIMARY INSURANCE COMPANY:

_____.

86g) *Address of PRIMARY insurance company for claim submittal*: _____

86h) *Type of policy: [encircle one**]: HMO? PPO?** Other* _____? 86i) *Amount **of Co-pay**?* $____.00

86j) *Has the **deductible,** if any, been paid for this year? [**Encircle**]: **YES** NO UNSURE NOT APPLICABLE.*

***86k)** ***Name of** SECONDARY INSURANCE COMPANY:*_____.

87a) Bills not paid within 60 days will include a 1.6% finance charge per month. A 35% fee will be added if turned over to collection.

87b) I agree to pay deductibles & balances not covered by insurance.

Patient Signature required: _____ **Date:** ___/___/___