EXCELLENT VISION

DRY EYE & REJUVENATION CENTER / DR EDWARD JACCOMA, MD / DR JILL FEDERICO, OD

Dear Patient,

Welcome to our practice! Please fill out the enclosed forms and mail them back to us prior to your upcoming appointment using the self-addressed, pre-stamped envelope included in this mailing.

Dry Eye Evaluations are lengthy appointments. Please be prepared to be in the office a minimum of 2 hours. You will have several tests to decipher how and why your eyes are dry before meeting with the doctor.

- Be sure to list ALL your medications, including vitamins, dietary supplements, and over-the-counter medications on your form.
- Please refrain from rubbing or itching your eyes the day of your appointment.
- If you wear glasses, please bring them to your appointment.
- If you are a contact lens wearer, please come in wearing your glasses and **NOT YOUR CONTACT LENSES.**
- If you have prior eye doctor records, it would be helpful for us to have them prior to your appointment.
- If you have any prescription eye drops or ointments, please bring them with you.
- Please **DO NOT** use any eye drops in your eyes on the day of your appointment.
- We would prefer *no eye makeup* on the day of your appointment.

Please bring your insurance cards and photo ID to be scanned and entered into our system at check-in. If your insurance requires a referral, it is your responsibility to call your Primary Care Physician prior to your appointment to obtain one. They may fax the referral to us directly at 603-430-1230. Co-payment is expected at the time of service, if applicable.

If you have any further questions or need clarification you may contact us at 603-430-5225 or Toll Free at 1-877-474-2020.

We look forward to assisting you with your eye care needs!

- *Excellent Vision Staff*

EXCELLENT VISION EYE & LASER

DRY EYE & REJUVENATION CENTER

155 Griffin Road

Portsmouth, NH 03801

603-430-5225

www.excellentvision.com

Directions to Portsmouth, NH office:

We are located at 155 Griffin Road. Traveling North on I-95, take exit 3, then take a right onto Route 33. Go through one set of lights, then take a right at the second light onto Griffin Road. The Harbour Health Building is the first medical arts building on the left. Enter through the main door, reception is on the right.

Traveling South on I-95, take exit 3B. Take a right onto Route 33. You will go through three sets of lights and then take a right at the fourth set of lights. Harbour Health building is on the left.

PATIENT HISTORY

TODAY'S DATE_____

NAME _____ DATE OF BIRTH _____

Preferred Name: _____ Preferred Pronouns: _____

ADDRESS_____CITY_____STATE_____ZIP_____

MAILING ADDRESS (If different) _____

CITY _____ STATE _____ ZIP _____ SOCIAL SECURITY #_____

HOME PHONE (_____) _____ WORK PHONE (_____) _____

MOBILE PHONE (_____) _____ EMAIL_____@_____

EMERGENCY CONTACT _____RELATIONSHIP_____PHONE (_____) _____

EMPLOYER_____ OCCUPATION:_____

PRIMARY PHYSICIAN_____PHONE (_____) _____

OPTOMETRIST _____ CITY: _____

PHARMACY _____ PHONE (_____) _____

HOW DID YOU HEAR ABOUT US? **REFERRED BY:**

DOCTOR: _____ *or* INDIVIDUAL: _____ *or* RADIO: WOKQ ___ Other_____

Questions relating to the Patient Protection and Affordable Care Act (ACA) 2010:

PREFERRED LANGUAGE: _____

ETHNICITY: ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Decline to answer ___ Unknown

RACE ___ American Indian ____ Alaska Native ___ Asian ___ Black or African American
___ Native Hawaiian ___ Other Pacific Islander ___ White ___ Decline to answer ___ Unknown

MEDICAL INSURANCE: 1. _____2. _____

VISION INSURANCE: _____ ID#_____

MARITAL STATUS: SINGLE / MARRIED / WIDOWED / DIVORCED

SPOUSE / NEXT OF KIN_____PHONE_____

Past OCULAR History (Past EYE History)

Have you had or been diagnosed with any of the following:

____ Eye Trauma – Type: _____ when: _____

____ Cataracts ____ Recurrent Corneal Erosion ____ Keratoconus ____Allergic Conjunctivitis

____ Glaucoma ____ Corneal Ulcers ____ Iritis ____ Herpes Keratitis (Eye Condition)

____ Dry Eye Syndrome ____ Corneal Scars ____Lazy or Crossed Eye(s) ___Shingles of the Eye

Previous EYE Surgeries (please list the eye and approximately when the surgery occurred)

PLEASE INDICATE IF NONE

1. _____
2. _____
3. _____
4. _____
5. _____

DO YOU TAKE ANY EYE DROPS OR EYE MEDS? *Please Indicate If NONE*

1 _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

PAST MEDICAL HISTORY

Please CHECK if you now have or have ever had any of the following:	YES	NO	When the incident occurred or when the condition was diagnosed:
DIABETES	____	____	_____
HIGH BLOOD PRESSURE	____	____	_____
HIGH CHOLESTEROL	____	____	_____
ASTHMA	____	____	_____
COPD / EMPHYSEMA	____	____	_____
HEART ATTACK	____	____	_____
ANGINA	____	____	_____
BLEEDING DISORDER	____	____	_____
G.I. DISEASE	____	____	_____
LIVER DISEASE / HEPATITIS	____	____	_____
KIDNEY DISEASE / STONES	____	____	_____
PERIPHERAL VASC DISEASE	____	____	_____
TUBERCULOSIS	____	____	_____
IRREGULAR HEARTBEAT	____	____	_____
CARDIAC PACEMAKER	____	____	_____
STROKE	____	____	_____
ANEMIA	____	____	_____
HAYFEVER	____	____	_____
BRONCHITIS	____	____	_____
PNEUMONIA	____	____	_____
STOMACH ULCER	____	____	_____
RHEUMATOID ARTHRITIS	____	____	_____
CANCER/TUMOR	____	____	_____
include location/treatment	____	____	_____
SEIZURES	____	____	_____
MYASTHENIA GRAVIS	____	____	_____
PSYCHIATRIC *please specify*	____	____	_____
DEMENTIA	____	____	_____
VARICOSE VEINS/BLOOD CLOTS	____	____	_____
SHINGLES	____	____	_____

PREVIOUS SURGERIES: **YEAR:**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

WHAT MEDICATIONS DO YOU TAKE REGULARY? *Please indicate if NONE*

	DOSAGE	**TIMES DAILY**
1.		
2.		
3.		
4.		
5.		

ALLERGIES: *Please indicate if NONE*

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

FAMILY HISTORY:

	YES	**NO**	**RELATIVE(S):**
GLAUCOMA	____	____	_____
CATARACTS	____	____	_____
MACULAR DEGENERATION	____	____	_____
OTHER RETINAL DISEASES	____	____	_____
COLOR BLINDNESS	____	____	_____
UNEXPLAINED VISUAL LOSS	____	____	_____
BLINDNESS	____	____	_____

SOCIAL HISTORY: *Please Circle the Appropriate Answer*

SMOKING
1. Current Every Day Smoker
2. Current Some Day Smoker
3. Former Smoker
4. Never Smoked

ALCOHOL USE
1. Never Former
2. Rarely
3. Occasionally
4. Daily
5. Frequent
6. Heavy

SUBSTANCE / DRUG USAGE
1. Never Former
2. Rarely
3. Occasionally
4. Daily
5. Frequent
6. Heavy

Type of Tobacco
1. Cigar
2. Cigarettes
3. Pipe
4. Vaping

Type of Alcohol
1. Beer
2. Liquor
3. Wine

Type of Drug / Substance
1. Marijuana
2. Amphetamine
3. IV Drugs, LSD
4. Cocaine

OCCUPATION
Business
Manual Labor
Office Work
Retired
Student

HOBBIES
Computer
Music
Sewing/Knitting
Sports
Travel

ANY FALLS WITH AN INJURY?
None
1 or more Falls in the current year
2 or more Falls in the past year.

DO YOU DRIVE? YES NO

REVIEW OF SYSTEMS: DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS CURRENTLY?
PLEASE CIRCLE THE APPROPRIATE CHOICES BELOW

Allergy/Immunology: Autoimmune Disease, Seasonal Allergies

Cardiovascular: Chest Pain, Shortness of Breath, Swelling of Feet, Racing Pulse, Irregular Heartbeat

Constitutional: Fever, Unexplained Weight Loss, Fatigue, Loss of Appetite, Chills, Night Sweats

Endocrine: Excess Thirst, Excessive Urination, Heat Intolerance, Cold Intolerance, Hair Loss, Dry Skin

Gastrointestinal: Heartburn, Abdominal Pain, Nausea, Diarrhea, Stomach Ulcers, Constipation, Trouble Swallowing

Genitourinary: Urgency, Frequent Urination, Bladder Trouble, Dialysis, Kidney Disease, Prostate Disease

Hematology: Easy Bruising, Prolonged Bleeding, Blood in Stools or Urine, Coughing Up Blood

HENT: Hearing Loss, Ringing In Ears, Sore Throat, Runny Nose, Dry Mouth, Jaw Claudication, Ear Ache

Integumentary: Rash, Skin Sores, Skin Lesions, Skin Cancer, Severe Itching, Loss of Hair

Musculoskeletal: Muscle Aches, Joint Pain, Difficulty Lying Flat, Back Pain

Neurologic: Weakness, Headaches, Scalp Tenderness, Dizziness, Poor Balance, Paralysis, Tremor, Numbness, Tingling, Fainting

Psychiatric: ADHD, Bipolar Disorder, Irritability, Nervousness, Anxiety, Depression, Dementia, Alzheimer's

Respiratory: Wheezing, Cough, Severe or Frequent Colds, Difficulty Breathing

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*I hereby authorize and direct the above-named insurance company to pay benefits directly to Northeast Corneal Consultants, PA (dba **Excellent Vision Eye and Laser Center**). I further authorize this office, **Excellent Vision Eye and Laser Center**, to release to the above-named insurance company any medical information necessary to obtain payment for my treatment. I understand my insurance company will be billed on my behalf and I am responsible for all fees, deductibles, co-payments, and any unpaid portion of my bill.*

*I certify the above information is true and correct to the best of my knowledge and will notify **Excellent Vision Eye and Laser Center** of any changes of the above stated information.*

Should this account go delinquent, you may be responsible for all additional fees, collection fees, attorney fees, court costs, and administration fees.

PATIENT'S SIGNATURE: _____ Date: _____

Patient's Legal Guardian (if necessary): _____ Date: _____

Lifestyle Vision Questionnaire

Name : _____ **Date :** _____

We recognize that your eyes are very important to you. We would like to know how *YOU* use your eyes daily. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal lifestyle vision.

- Do you wear glasses now? ____No If Yes: ____ All the time ____ Sometimes
  ____Only for far distance ____Only for reading ____ Only for computer
- How important is it for you to read or use computer without glasses?
  ____Very important ____ Important ____ Not important
- How many hours per day do you: read? _____ use computer? _____
- Where do you hold a book when reading? ____ close to face ____ chest level ____ in your lap
- Percentage of reading in bright light (outdoors) _____% vs. low light settings (menu, bedtime) _____% ?
- How do you *feel* about wearing glasses? _____
- If it were possible to go without glasses for most of the time, would you like that? ____No ____Yes
- Do you drive at night? ___No If Yes: ___Occasionally ___ Nightly ____As profession (truck, cab)
- What occupational, recreational, or other activities do you currently engage in that are not listed above?_____

CIRCLE the following activity(s) you do on a regular basis:

Read Newspaper, Books, Labels (daytime / nighttime / BOTH)			Sew/Needlepoint
Computer-desktop	iPad or Laptop	Smart/Cell Phone	Paperwork / Writing
Drive daytime	Drive nighttime	Shop	Golf
Tennis	Hunt or Fish	Paint / Artist	Cook
Musician	Play Cards / Dominos	Movie Theatre	Dine in Restaurant
Photography	Spectator Sports	Bicycle, Roller blade, Hike, etc.	

UNDERLINE any of the above activity(s) that you would like to do *without glasses if possible.*

Please place an "X" on the following scale to describe your personality as best you can:

Easy going Perfectionist

SPEED™ QUESTIONNAIRE

Name: _____ **Date:** ____/____/____ **Sex:** M F (Circle) **DOB:** ____/____/____

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. Report the type of SYMPTOMS you experience and when they occur:

	At this visit		Within past 72 hours		Within past 3 months	
Symptoms	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the FREQUENCY of your symptoms using the rating list below:

Symptoms	**0**	**1**	**2**	**3**
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never **1** = Sometimes **2** = Often **3** = Constant

3. Report the SEVERITY of your symptoms using the rating list below:

Symptoms	**0**	**1**	**2**	**3**	**4**
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No Problems
1 = Tolerable - not perfect, but not uncomfortable
2 = Uncomfortable - irritating, but does not interfere with my day
3 = Bothersome - irritating and interferes with my day
4 = Intolerable - unable to perform my daily tasks

4. Do you use eye drops for lubrication? ☐ **YES** ☐ **NO** **If yes, how often?** _____

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For office use only
Total SPEED score (Frequency + Severity) = ____/28