I-Brite - Ocular/Medical/General Information

Date _____
Phone _____

Name _____
(First) (Middle) (Last)

Date of Birth_____Age_____Gender_____Occupation _____

Address _____City_____State_____Zip_____

Please describe what is abnormal about the appearance of your eyes that bothers you?

What frustrations do you have now because of your eyes?

Do you avoid activities, hobbies, places, people etc. because of your eyes?

Glasses History

1. How often do you wear eyeglasses or contact lenses for distance vision? ☐ Not at All ☐ Part-time ☐ Full-time
2. Do you need eyeglasses for reading? ☐ Yes ☐ No

Contact Lens History

3. Do you currently wear contact lenses? ☐ Yes ☐ No (if no, skip to 9 – Ocular History)
4. What kind of contact lenses do you wear now? ☐ soft ☐ rigid gas permeable
5. Do you notice increase redness with contacts? ☐ Yes ☐ No
6. Do your eyes feel dry with contacts? ☐ Yes ☐ No
7. Do you use artificial tears with contacts? ☐ Yes ☐ No

Ocular History

8. List all eye surgeries, indicate date and eye: _____

_____

9. List eye injuries, indicate date and eye: _____

10. Previously treated or diagnosed with Dry Eyes? ☐ Yes ☐ No

    Previously treated or diagnosed with Blepharitis? ☐ Yes ☐ No

    Previously treated or diagnosed with Styes? ☐ Yes ☐ No

Previously treated or diagnosed with Glaucoma? ☐ Yes ☐ No

Previously treated or diagnosed with Cataracts? ☐ Yes ☐ No

Previously treated or diagnosed with other eye conditions: ☐ Yes ☐ No

If yes, what? _____

_____

11. Do you use artificial tears? ☐ Yes ☐ No

If yes, how often? ☐ 1-4x's daily ☐ 5-8x's daily ☐ few times a week ☐ occasionally

Do you use Visine, Clear Eyes or "get the red out" drops? ☐ Yes ☐ No

If yes, how often? ☐ daily ☐ few times weekly ☐ few times monthly ☐ occasionally

Do you use other eye drops? ☐ Yes ☐ No

If yes, indicate eye, type & frequency _____

Family Ocular History

12. List any eye diseases that run in your family: _____

_____

General Medical History

13. List any medications you are allergic to: _____

14. Do you smoke? ☐ yes ☐ no

If so, how much per day: _____

15. Have you previously undergone any cosmetic procedure(s): ☐ yes ☐ no

If yes, what procedures: _____

If yes, did you heal as expected? _____

16. List other surgeries you have had, with dates: _____

_____

17. Do you feel that you didn't heal from a medical procedure as expected? ☐ yes ☐ no

If yes, please explain: _____

_____

_____

18. Do you feel like doctors ignored your medical concerns (not eye related)? ☐ yes ☐ no

If yes, please explain: _____

_____

_____

19. Do you feel like the quality of care provided by your previous eye doctor has been unsatisfactory? ☐ yes ☐ no

If yes, please explain: _____

_____

_____

20. Do you feel like a doctor didn't deliver quality results for your medical care? ☐ yes ☐ no

If yes, please explain: _____

_____

_____

21. Current medications/Recreational Drugs: _____

_____

_____

22. Current vitamins/supplements: _____

_____

_____

23. If female,

are you or might you be pregnant? ☐ yes ☐ no

are you trying to become pregnant? ☐ yes ☐ no

are you breastfeeding? ☐ yes ☐ no

24. **Please check any of the following that has been suspected or treated, currently or in the past:**

Adrenal Disorders
☐Addison's Disease
☐Cushing's Syndrome

Arthritis, Bone or Joint
☐Gout
☐Psoriatic Arthritis
☐Reiter's Syndrome
☐Rheumatoid Arthritis
☐Spondylitis

Blood/Artery or Cardiac
☐Anemia - Aplastic
☐Anemia - Hemolytic
☐Anemia - Pernicious
☐Anemia - Sickle-cell
☐Erythropoietic Porphyria
☐Vitamin B12 Deficiency
☐Waldenstrom's Macroglobulinemia

Connective Tissue Disorders
☐Dermatomyositis
☐Lupus
☐Connective Tissue Disease
☐Raynaud's
☐Relapsing Polychondritis

Gastro-Intestine Conditions
☐Celiac Disease
☐Crohn's Disease
☐Inflammatory Bowel Disease
☐Ulcerative Colitis

Infectious Diseases
☐Lyme Disease
☐Syphilis

Infectious Diseases cont.
☐Tuberculosis
☐Other _____

Immune Disorders
☐AIDS
☐HIV

Inflammatory Conditions
☐Ankylosing Spondylitis
☐Pancreatitis
☐Sarcoidosis

Liver Conditions
☐Elevated Bilirubin
☐Gilbert Syndrome
☐Hepatitis

Neurologic or Muscular
☐Fibromyalgia
☐Inflammatory Neuropathy
☐Leprosy
☐Multiple Sclerosis
☐Myasthenia Gravis
☐Myositis
☐Polymyalgia Rheumatica

Ophthalmic Conditions
☐Cogan's Syndrome
☐Glaucoma
☐Ophthalmic Herpes Zoser
☐Scleritis
☐Scleromalacia Perforans
☐Sjogren's Syndrome
☐Uveitis

Skin Conditions
☐Atopy

Skin Conditions cont.
☐Atopic Dermatitis
☐Erythema Nodosum
☐Erythema Multiforme
☐Granuloma Annulare
☐Porphyria
☐Psoriasis
☐Scleroderma

Systemic, Vascular or Organ
☐Behcet's Disease
☐Berger's Disease
☐Blood Pressure (high/low)
☐Cancer Type _____
☐Churg-Strauss Syndrome
☐Diabetes
☐Gallbladder Conditions
☐Giant-Cell Arteritis
☐Goodpasture Syndrome
☐Heart Disease
☐Kawasaki's Disease
☐Kidney Disease
☐Liver Disease
☐Periarteritis Nodosa
☐Takayasu Disease
☐Vasculitis
☐Wegener's Granulomatosis

Thyroid Conditions
☐Grave's Disease
☐Hashimoto's Thyroiditis
☐Hyper or Hypo Thyroidism

Viral Disease
☐Herpes Zoster
Where: _____
☐Herpes Simplex
Where: _____
☐Shingles

25. List any other immune or auto-immune conditions: _____

26. List any other medical conditions not previously noted: _____

27. Have you ever been declined any surgery of any kind from another doctor? ☐ yes ☐ no

If yes, please explain: _____

Family Medical History

28. Do you have family history Auto-Immune diseases? ☐ yes ☐ no

If yes, what? _____

_____

Other Info

29. If you were referred to us, who referred you? ☐ Doctor ☐ Boxer Wachler Patient ☐ Other

Where can we send a thank you letter and gift to your referral?

Address_____

Street City State Zip Code

Phone # (_____)_____

30. Primary Eye Doctor Name _____

(check one) ☐ OPTOMETRIST ☐ OPHTHALMOLOGIST

Address_____

Street City State Zip Code

Phone # (_____)_____

31. Primary Medical Doctor Name _____

Address_____

Street City State Zip Code

Phone # (_____)_____

32. Other doctors/specialists providing medical care: (list name/phone number)

_____

_____

35. May we send a letter to your doctors to update them on your visit(s) with us? ☐ yes ☐ no

May we send your medical records to your doctors if they request them? ☐ yes ☐ no

Sign to authorize us to release records _____ Date _____

Questionnaire

Date: _____Patient Name: _____Date of Birth: _____

Place an X on the scale toward the direction that best rates your response to the questions below

How often do you use "get the red out" eye drops?
Never Rarely Weekly Daily

How often do you use artificial tears?
Never Rarely Weekly Daily

How often are your eyes red when you wake up?
Never Rarely Weekly Daily

Do you worry about the appearance of your eyes?
Never Rarely Weekly Daily

How unhappy are you with the appearance of your eyes?
Not at All Slightly Moderately Extremely

How much distress do you experience from the appearance of your eyes?
None Slight Moderate Extreme

How much time do you spend each day thinking about the appearance of your eyes?
None less than 1 hour 4-8 hours 8+ hours

How often does the appearance of your eyes affect your ability to work?
Never Occasionally All the time

How often does the appearance of your eyes affect your outlook on life?
Never Occasionally All the time

How else has the appearance of your eyes affected you:

……

……

……