NEW PATIENT INFORMATION

Today's Date: ______________ Email address: _________________________________

PERSONAL INFORMATION – (Please Print)

Patient Name: ____Age: _____________

Address: ________________________ City ___________________ State ___________ Zip ________

Home Phone: (______)__________________________ Work Phone:(____)____________________

Date of Birth: ____________________ S.S. #: _________________________

Sex: Male / Female

Marital Status: Single o **Married** o **Divorced** o **Widowed** o

Employment Status Employedo **Unemployed**o **Retired**o **Disabled** o
Employer: ___________________________________ Occupation:_________________________
Work Phone: ________________________________

Spouse's Name: _________________________________Spouse's Date of Birth:_______________
Employer: ___________________________ Work Phone: ________________________________

Primary Care/ Family Doctor: ____

Referred by:
o **Friend/Relative ____________________________** o**Doctor: ___________________________**

o**Internet** o**Insurance** o**Website** o**Other: ____________________________**

Who to notify in an emergency (nearest relative or friend)?

Name: __________________________________Relationship: ____________________________
Phone: _____________________________________

Complete if under 18 years or a student

Name of Father: ____________________________Social Security # ________________

Phone: ___________________________________

Name of Mother: __________________________ Social Security # ________________

Phone_____________________________________

INSURANCE INFORMATION (Please bring insurance cards and drivers license to the front desk)

Primary Insurance: ______________________________ # _______________________
Co-pay Amount:________________

Name of:

Policyholder: ________________________________Social Security # _______________________

Date of Birth: _______________

Secondary Insurance: _______________________________ # __________________________

Co-pay Amt: ____________

Name of:

Policyholder: ________________________________Social Security # _______________________

Date of Birth: _______________

Patient Name: ____________________________________

FINANCIAL ASSIGNMENT AND AGREEMENTS

- **I also acknowledge that for the purpose of evaluation, my pupils may be dilated. This may result in blurred vision, making driving difficult. Please ask for assistance if your vision is markedly affected.**
- **I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to (Rothchild Eye Institute) for any services furnished me by them. I authorize any holder of Medical information about me to release to the Health Care Financing Administration, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.**
- **I understand that I am financially responsible for all charges not covered by insurance.**
- **I give permission to (Rothchild Eye Institute) to access records regarding my medical conditions.**
- **I authorize (Rothchild Eye Institute) to communicate with me by phone, answering machine, letter or email at home or business regarding appointments, care or billing.**
- **I agree to the release of my medical information to my personal physician(s), or optometrist(s).**

- **I give permission to discuss my medical information with the specific individuals named below: (examples: spouse, adult children, caregiver, emergency contact)**

1. ______________________________ **2.** ______________________________

3. ______________________________ **4.** ______________________________

I acknowledge that a copy of (Rothchild Eye Institute) Notice of Privacy Practices has been provided to me for review and that a copy is available at my request.

Signature: ____ **Date:** ____________

(Patient or legal guardian)

Witness: ____ **Date:** ____________

(Practice Representative)

ERIC F. CILIBERTI, M.D.

Neuro-Ophthalmology Questionnaire

Date_____________________

Name____________________________________Date Of Birth_______________Age_____

Sex: M F Race___________ Marital Status_____________Occupation_____________

Please List ALL medical problems for which you take medicine:

1.____________________2.____________________3_______________________

4.____________________5.____________________6.______________________

7.____________________8.____________________9.______________________

Please list ALL prior major surgeries and dates (including eye surgeries):

1._________________________________ 2._______________________________

3._________________________________4.________________________________

5._________________________________6.________________________________

Please list ALL current daily prescriptions medications & eye drops; including aspirin:

Medication Name	Dose (mg)	How Often do you take it?
1.____________________	___________	___________________
2.____________________	___________	___________________
3.____________________	___________	___________________
4.____________________	___________	___________________
5.____________________	___________	___________________
6.____________________	___________	___________________
7.____________________	___________	___________________

Have you taken any of the following medications in the last year? (circle any that apply)

Amiodarone (Cordarone) Ethambutol Isoniazid Viagra/Cialis/Levitra

Digoxin/Lanoxin Vincristine Cyclosporine Linezolid

Plaquenil (Hydroxychloroquine) Dilantin (Phenytoin) Accutane (Isotrentoin)

List ALL medications you are allergic to: ____

List ALL prior eye problems:____

Have you ever been prescribed prism glasses? Yes No

If yes, when ________________ By Whom?__________________________________

Have you ever smoked? Y N How many years?________ #of packs daily_______Quit Y N When______

Ever consumed alcohol? Y N How many years?________ #drinks weekly______Quit Y N When______

Any medical problems that run in the family? If so, please describe illness and which family members were affected____

Have you ever been diagnosed or treated for any of the following conditions?

High Blood Pressure Yes No
Neuropathy Yes No
Diabetes Yes No
Cancer/type____________ Yes No
Migraine Yes No
Meningitis Yes No
Brain Tumor Yes No
Syphillis Yes No
Epilepsy/Seizures Yes No
Sarcoidosis Yes No
Hypothyroidism Yes No
Lyme Disease Yes No
Hyperthyroidism Yes No
Cat-Scratch Disease Yes No
Myasthenia Gravis Yes No
Myopathy (Muscle Disease) Yes No
Grave's Disease Yes No
Multiple Sclerosis Yes No
Stroke or TIA Yes No
Alcoholism Yes No
Parkinson's Disease Yes No
Lupus (SLE) Yes No
Horner's Syndrome Yes No
Bleeding Disorder Yes No
Bell's Palsy Yes No
Hydrocephalus (Water on the brain) Yes No
Amblyopia or Lazy Eye Yes No
Coronary Artery Disease Yes No
Retinal Detachment Yes No
HIV or AIDS Yes No
Glaucoma Yes No
Herpes Yes No

Optic Neuritis Yes No
Temporal or Giant Cell Arteritis Yes No
Head Trauma Yes No
Pseudotumor Cerebri Yes No
Trigeminal Neuralgia Yes No
Blepharospasm Yes No
Hemifacial Spasm Yes No
Peptic Ulcer Disease/Gastritis Yes No
Osteoporosis Yes No
Scleroderma Yes No
Vertigo Yes No
Fibromyalgia Yes No
Tuberculosis (TB) Yes No
Temporomandibular Jt Synd (TMJ)
Asthma Yes No
Kidney Stones Yes No
Seasonal Allergies Yes No
Arrhythmia Yes No
High Cholesterol Yes No
Prostate Enlargement Yes No
Menstrual Abnormalities Yes No
Heart Failure Yes No
Sinusitis Yes No
Skin Cancer Yes No
Breast Cancer Yes No
Kidney Failure Yes No
Vitamin B12 Deficiency Yes No
Anemia Yes No
Liver Failure Yes No

Have you ever been prescribed prism glasses? YES NO

If Yes when_____________________ By Whom ___________________________________

Have you ever smoked? YES NO

How many years___________ # of packs daily________

Quit YES NO When?_________

Ever consumed alcohol?________ How many years___________

# of drinks weekly________

Quit YES NO When?_________

Have you ever been diagnosed or treated for any of the following conditions?

High Blood Pressure	YES	NO	Optic Neuritis	YES	NO
Neuropathy	YES	NO	Temporal or Giant Cell Arteritis	YES	NO
Diabetes	YES	NO	Head Trauma	YES	NO
Cancer/Type_______________	YES	NO	Pseudotumor Cerebri	YES	NO
Migraine	YES	NO	Trigeminal Neuralgia	YES	NO
Meningitis	YES	NO	Blepharospasm	YES	NO
Brain Tumor	YES	NO	Hemifacial Spasm	YES	NO
Syphillis	YES	NO	Peptic Ulcer Disease/Gastritis	YES	NO
Epilepsy/Seizures	YES	NO	Osteoporosis	YES	NO
Sarcoidosis	YES	NO	Scleroderma	YES	NO
Hypothyroidism	YES	NO	Vertigo	YES	NO
Hyperthyroidism	YES	NO	Fibromyalgia	YES	NO
Lyme Disease	YES	NO	Tuberculosis	YES	NO
Cat-Scratch Disease	YES	NO	Temporomandibular Jt Synd (TMJ)	YES	NO
Myasthenia Gravis	YES	NO	Asthma	YES	NO
Myopathy (Muscle Disease)	YES	NO	Kidney Stones	YES	NO
Grave's Disease	YES	NO	Seasonal Allergies	YES	NO
Multiple Sclerosis	YES	NO	Arrhythmia	YES	NO
Stroke Or TIA	YES	NO	High Cholesterol	YES	NO
Alcoholism	YES	NO	Prostate Enlargement	YES	NO
Parkinson's Disease	YES	NO	Mentrual Abnormalities	YES	NO
Lupus (SLE)	YES	NO	Heart Failure	YES	NO
Horner's Syndrome	YES	NO	Sinusitis	YES	NO
Bleeding Disorder	YES	NO	Skin Cancer	YES	NO
Bell's Palsy	YES	NO	Breast Cancer	YES	NO
Hydrocephalus (water on the brain)	YES	NO	Kidney Failure	YES	NO
Amblyopia or Lazy Eye	YES	NO	Vitamin B12 Deficiency	YES	NO
Coronary Artery Disease	YES	NO	Anemia	YES	NO
Retinal Detachment	YES	NO	Liver Failure	YES	NO
HIV or AIDS	YES	NO		YES	NO
Glaucoma	YES	NO		YES	NO
Herpes	YES	NO			

REVIEW OF SYSTEMS

Have you recently had?

If Yes, provide any additional details (i.e. when it began, if intermittent: how long it lasts, how often it occurs, etc.) along the right side of the page.

1. Dizziness YES NO
Spinning Sensation/ Lightheadedness
Triggered by change in body posture or head position

2. Numbness YES NO

3. Tingling YES NO

4. Fatigue/Lethargy YES NO

5. Muscle weakness YES NO

6. Muscle aches YES NO

7. Balance difficulty YES NO

8. Loss of coordination YES NO

9. Ringing in the ears (tinnitus) YES NO

10. Scalp tenderness/soreness to the touch YES NO

11. Fever YES NO

12. Neck Pain YES NO

13. Difficulty swallowing YES NO

14. Difficulty speaking YES NO

15. Pain in the jaw w/chewing YES NO

16. Weight loss YES NO
If Yes how much ____________

17. Depression YES NO

18. Poor color vision YES NO

19. Anxiety/Nervousness YES NO

20. Blurred vision/circle below or if No skip to next question
Right Eye Left Eye Both Eyes Fluctuating Constant At Distance While Reading

21.Temporary Loss of Vision YES NO

Right Eye Left Eye Both Eyes **YES NO**
How Often has this happened? ___________________________
How long did it last?____________________________________

22. Blind Spots in the vision? **YES NO**

23. Eye Pain or discomfort? **YES NO**

24. Double Vision: **YES NO**
a. Does the double vision go away when: **YES NO**
right eye is closed **YES NO**
left eye is closed **YES NO**
b. Are the objects double (circle all that apply)
Side by Side One on top of the other

25. Drooping of one or both eyelids **YES NO**

26. Flashing lights in your vision **YES NO**

27. Floaters **YES NO**

28. Facial Pain **YES NO**

29. Headache (circle all that apply below) **YES NO If No skip to #30**
Throbbing/pulsating Squeezing/pressure-like feeling Aching sensation Sharp

30. Nausea or vomiting **YES NO**

31. Loss of consciousness **YES NO**

32. Sinus Congestion **YES NO**

33. Chronic Cough **YES NO**

34. Dry mouth/throat **YES NO**

35. Decreased Hearing **YES NO**

36. Shortness of Breath/Wheezing **YES NO**

37. Chest Pain **YES NO**

38. Muscle Pain **YES NO**

39. Joint Pain **YES NO**