NORTHEASTERN STATE UNIVERSITY
Oklahoma College of Optometry
LESLEY L. WALLS VISION CENTER

3100 East New Orleans
Broken Arrow OK 74014
918-449-6210, 918-449-6219 fax

Personal Information

Last Name _____ First Name _____ MI _____

Address _____ City _____ State ____

Zip _____ Phone ___-___-_____ Cell___-___-_____

Sex ☐ M / ☐ F Date of Birth ___/___/_____ SSN ___-___-_____

E-mail address:_____

Race: ☐ Asian / ☐ Caucasian / ☐ Native Am. / ☐ African-Am. / ☐ Hawaiian-Pac. Islander

Ethnicity: Hispanic/Latino ☐/☐ Not Hispanic/Latino

Preferred Language _____ Previous Names_____

Marital Status: ☐ Single / ☐ Married / ☐ Divorced / ☐ Widowed / ☐ Leg. Separated

In case of emergency call: Name _____

Phone ___-___-_____ Relationship _____

Name of Primary Care Doctor _____

Insurance Information

Medical Insurance _____

Responsible Party: ☐ Self / ☐ Spouse / ☐ Parent

Vision Insurance _____

(patient is responsible for any copays and what insurance does not cover)

Your Goals

Loss of vision can cause difficulties in accomplishing daily tasks. Please think about the activities that have provided the most difficulty for you as a result of your vision loss, and list them here:

1. (Most Important) _____
2. _____
3. _____
4. _____

If you use any magnifying devices to assist you in your daily activities, please bring them with you to your evaluation. Also bring any eyeglasses you use.

Medical History Questionnaire

Social History

Do you use cigarettes/tobacco? ☐ ☐ Y / N

Do you use other substances? ☐ ☐ Y / N

Do you use alcohol? ☐ ☐ Y / N

Occupation

_____

Hobbies

_____

Surgical History

List eye surgeries you've had

_____

_____

List other surgeries you've had

_____

_____

Eye Information	Personal	Family History
Do you or have you had?		
Glaucoma	☐☐ Y / N	☐☐ Y / N
Cataracts	☐☐ Y / N	☐☐ Y / N
Macular Degeneration	☐☐ Y / N	☐☐ Y / N
Retinal Disease	☐☐ Y / N	☐☐ Y / N
Blindness	☐☐ Y / N	☐☐ Y / N
Strabismus(eye turn)	☐☐ Y / N	☐☐ Y / N
Amblyopia (lazy eye)	☐☐ Y / N	☐☐ Y / N
Headaches	☐☐ Y / N	☐☐ Y / N
Eye injury	☐☐ Y / N	
Dry Eyes	☐☐ Y / N	
Glasses	☐☐ Y / N	
Contact Lenses	☐☐ Y / N	
Do you use a computer?	☐☐ Y / N	
Hours per day _____		
Other Problems? _____		

Please List Your Current Medications

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergy Information List any medications you are allergic to

_____ Reaction Type_____

_____ Reaction Type_____

Any Other Allergies? _____

Medical Information	Personal	Family History	Examples
Do you or have you had?			
Diabetes	☐ ☐ Y / N	☐ ☐ Y / N	
High Blood Pressure	☐ ☐ Y / N	☐ ☐ Y / N	
Allergic/Immune Disease	☐ ☐ Y / N	☐ ☐ Y / N	(Allergies, HIV)
Cardiovascular Disease	☐ ☐ Y / N	☐ ☐ Y / N	(Heart Disease, Murmur)
Ear/Nose/Throat Disease	☐ ☐ Y / N	☐ ☐ Y / N	(Hearing, Dry Mouth)
Endocrine (gland) Disease	☐ ☐ Y / N	☐ ☐ Y / N	(Thyroid, Pituitary)
Gastrointestinal Disease	☐ ☐ Y / N	☐ ☐ Y / N	(Ulcers, Heartburn)
Genitourinary Disease	☐ ☐ Y / N	☐ ☐ Y / N	(Kidney, Urinary)
Blood/Lymph Disease	☐ ☐ Y / N	☐ ☐ Y / N	(Bleeding, Anemia)
Integumentary (skin)	☐ ☐ Y / N	☐ ☐ Y / N	(Rashes, Sores, Dryness)
Musculoskeletal Disease	☐ ☐ Y / N	☐ ☐ Y / N	(Arthritis, Osteoporosis)
Nervous System Disease	☐ ☐ Y / N	☐ ☐ Y / N	(MS, Seizures)
Mental Health Disorder	☐ ☐ Y / N	☐ ☐ Y / N	(Depression, Alzheimer's)
Respiratory Disease	☐ ☐ Y / N	☐ ☐ Y / N	(Emphysema, Asthma)

What is your height? _____

What is your weight? _____

Do you have any other health problems? _____

_____

_____

Authorization For Release Of Identifying Health Information

Public Information Officer: Ms. Jennifer Jones, Coordinator of Clinical Management

Patient Name: _____

I am providing the Lesley L. Walls Vision Center my permission to release my information to:

1. The health care professional(s) who referred me to the Lesley L. Walls Vision Center and/or the health care professional(s) with whom I currently receive care and that I request the information be sent to, and
2. NewView Oklahoma, our non-profit partner with whom we provide care, if it is recommended and I agree to be referred to them.

I authorize the Lesley L. Walls Vision Center to release health information identifying me under the following terms and conditions. I understand the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but is not limited to, hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

1. Detailed description of the information to be released:
   Findings and recommendations from my low vision evaluation.
2. The purpose(s) for the release:
   To keep my relevant health care providers informed about my care and progress.
3. Expiration date for this release:
   Two years following my initial evaluation at the Lesley L. Walls Vision Center.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature _____Date ____/____/____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____

Print Name _____

Source of Authority _____

Thank you! Please bring this form with you to your appointment.