WELCOME

This is the new patient information for your upcoming appointment at the USF EYE Institute. Please read the information carefully. Complete the questionnaire that is included. Please make sure you bring your photo ID and insurance card.

We look forward to seeing you.
Please read carefully, sign and complete the attached forms and bring them with you to your scheduled appointment.

Welcome to the University of South Florida Eye Institute and thank you for choosing USF Eye Institute for your healthcare needs.

We recommend that you arrive 15 minutes prior to your appointment time. When you arrive for your appointment, a patient representative will provide you with a parking permit. Please place the permit on the dashboard of your vehicle to avoid a parking citation.

The faculty and staff with USF Eye Institute will make every effort to make your experience with us as pleasant as possible. Wait times can be longer than usual as we are a specialty office. You must bring a valid insurance card and photo ID with you at the time of service. It is your responsibility to know your insurance benefits.

RETINA PATIENTS

Please be aware a visit with one of our retina specialist may take up to 4-6 hours due to the extensive examination, diagnostic testing, and possible treatment you may receive. The temperatures in the clinic become chilly at times.

- Please bring a sweater or jacket to make yourself more comfortable.
- If you are diabetic please bring a snack just in case your blood sugar runs low.
- Please bring your eyeglasses or contacts with you even if you don’t wear them.
- Please feel free to bring your medical records and a list of all medications that you are currently taking.
NEURO-OPHTHALMOLOGY PATIENTS ONLY

If you have had an MRI, MRA CT scan, sleep study, EKG, Holter-Monitor, or lab work, please have the results faxed to Dr. Drucker’s attention at 816-974-0753 prior to your appointment. *It is not necessary to bring the actual films/CD with you to your visit, just the written report.*

PEDIATRIC PATIENTS

For children up to 8 years old, you may consider bringing a hat, jacket, or blanket for him or her to wear, as the clinic can become very chilly at times.

Please bring your child’s eyeglasses to their appointment, even if he or she does not currently wear them.

Please feel free to bring books, or toys to help keep your child occupied. There are video tapes in the waiting area for your child’s enjoyment.

**IMPORTANT NOTE** If the appointment is for a minor, a parent or legal guardian *must* accompany the child and sign the consent to treat a minor in front of a witness at the time of the appointment. If accompanied by anyone other than a parent, we will need to see either a court order stating that you have legal custody or you must bring in a notarized letter from the parent stating that you are authorized to accompany the minor and consent to treat, or the minor will not be seen (you must bring this to every office visit and present at time of check in).

Thank you for your cooperation.

*Laura Pearce*
Laura Pearce, MBA
Department Business Administrator
Department of Ophthalmology

*Trina Johnson*
Trina Johnson
Department Manager
Department of Ophthalmology
New Patient Health Questionnaire: Department of Ophthalmology

Date: ____________________

Patient Name: ________________________________ Medical Record Number: ____________________

Email Address: ________________________________

Age: _____  Sex:  Male____ Female___  Date of Birth: ________________________________

Type of Visit: _____ Consultation requested by another Physician  _____ Self Referred  _____ Second Opinion

PHYSICIAN INFORMATION

Primary Care: ________________________________ Specialty: ________________________________

Address: ____________________________________________

Phone: ___________________________ Fax: ___________________________

Referring Physician: ________________________________ Specialty: ________________________________

Address: ____________________________________________

Phone: ___________________________ Fax: ___________________________

Pharmacy Name: ________________________________ Phone: ________________________________

Fax #: ________________________________ Store #: ________________________________

Address: ____________________________________________

PERSONAL HISTORY

_____ Married  _____ Widowed  _____ Divorced  _____ Single

Currently Employed?  _____ Yes  _____ No  How Long? ________________________________

Do you live?  _____ With Spouse/Family  _____ Alone  _____ with others

Do you have a living will or advanced directive?  _____ Yes  _____ No

PLEASE NOTE THE REASON FOR YOUR VISIT

__________________________________________________________________________________
ALLERGIES  *(Specify drug and reaction)*

__________________________  ____________________________  ____________________________

MEDICATIONS/DOSE/FREQUENCY
*(include over the counter medications, herbal products, supplements and vitamins)*

__________________________  ____________________________

__________________________  ____________________________

__________________________  ____________________________

PAST MEDICAL HISTORY: *(Include all hospitalizations, chronic health problems, major illnesses)*

__________________________  ____________________________

__________________________  ____________________________

PAST SURGICAL HISTORY: *(List all past surgeries)*

__________________________  ____________________________

__________________________  ____________________________

PAST OCULAR HISTORY: *(List all past EYE surgeries, diseases and treatments)*

__________________________  ____________________________

SOCIAL HISTORY: *(Tobacco, alcohol or drug use)*

Do you currently smoke cigarettes? _____ Yes _____ No  How many packs?_________

Years?__________  Quit Date:__________________________

Do you currently consume alcohol? _____ Yes _____ No  What Type?________________  Amount per day__________

FAMILY HISTORY:  Fill in relationship to you *(Parent, Grandparent, Sibling, Aunt, Uncle or Child)* and
LIST ANY DISEASE THAT APPLIES. *(Glaucoma, Macular Degeneration, Heart disease, Diabetes...)*

<table>
<thead>
<tr>
<th>RELATIONSHIP</th>
<th>EYE DISEASE</th>
<th>OTHER DISEASE</th>
</tr>
</thead>
<tbody>
<tr>
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# REVIEW OF SYSTEMS:
Please circle any that apply

<table>
<thead>
<tr>
<th>General:</th>
<th>Allergic/Immunologic:</th>
<th>Respiratory:</th>
<th>Cardiovascular:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight Loss/Gain</td>
<td>Hay fever</td>
<td>Chronic Cough</td>
<td>Chest Pain</td>
</tr>
<tr>
<td>Trouble falling asleep</td>
<td>Immunodeficiency</td>
<td>Difficulty Breathing</td>
<td>Abnormal feet swelling</td>
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<tr>
<td>Fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extreme Fatigue</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th>Skin:</th>
<th>Gastrointestinal:</th>
<th>Hematologic:</th>
<th>Psychiatric:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rash</td>
<td>Frequent Heartburn</td>
<td>Anemia</td>
<td>Depression</td>
</tr>
<tr>
<td>Lump/Growth on skin</td>
<td>Blood in Stool</td>
<td>Excessive Bleeding</td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td>Stomach Ulcers</td>
<td>Blood Transfusion</td>
<td>Other________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Genitourinary:</th>
<th>Neurological:</th>
<th>Head, Ear, Nose and Throat:</th>
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</thead>
<tbody>
<tr>
<td>Painful Urination</td>
<td>Seizures</td>
<td>Difficulty Hearing</td>
</tr>
<tr>
<td>Blood in Urine</td>
<td>Numbness in arms/legs</td>
<td>Buzzing/Ringing in the ears</td>
</tr>
<tr>
<td></td>
<td>Weakness in arms/legs</td>
<td>Difficulty Swallowing</td>
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</tbody>
</table>

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<tr>
<th>Endocrine:</th>
<th>Musculoskeletal:</th>
<th>Frequent or severe headaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive Thirst</td>
<td>Painful Joints</td>
<td>Tumors</td>
</tr>
<tr>
<td>Hot/Cold Intolerance</td>
<td>Back Pain</td>
<td></td>
</tr>
</tbody>
</table>

**USF HEALTH**

DEPARTMENT OF OPHTHALMOLOGY
12901 Bruce B Downs Blvd, MDC 21
Tampa, Florida 33617

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Form #400-005 (3/16)
PRIOR EXPRESS CONSENT

FOR COMMUNICATIONS FOR DEBT COLLECTION AND PAYMENT PURPOSES

I expressly agree and consent that, in order for University Medical Service Association, Inc. ("UMSA"), and its agents and affiliates, to service my account including debt collection and payment purposes, UMSA, or any of its agents or affiliates, may contact me by telephone at any telephone number associated with my account, including any wireless/cellular telephone numbers, which could result in charges to me. UMSA, or any of its agents or affiliates, may also contact me for debt collection and payment purposes by sending text messages or e-mails, using any e-mail address I provide to UMSA. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device.

I have read this Consent and agree that UMSA may contact me as described above. I hereby affirm that either (i) I am the patient and sign this Consent of my own behalf, or (ii) if I am signing this Consent on behalf of the patient, I have reviewed this Consent with the patient and he/she has expressly authorized me to sign this Consent on his/her behalf.

______________________________  __________________________
Patient or Patient’s Authorized Representative  Date:

(relationship to Patient)

______________________________  __________________________
Patient Refused to Sign  Date

(Signature of USF Health Rep)