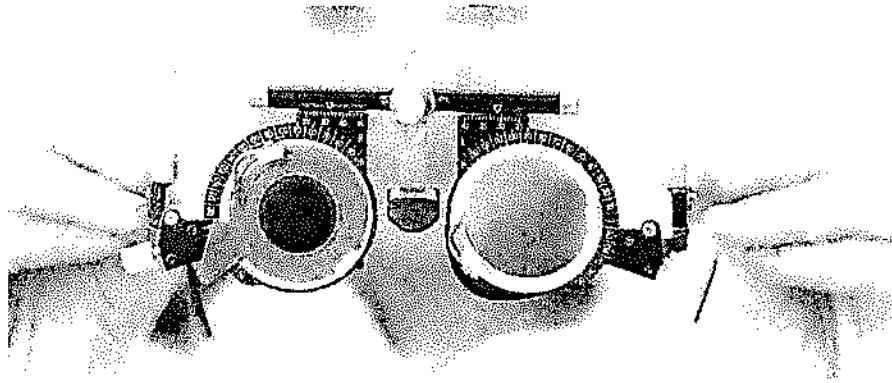




USF EYE INSTITUTE  
13127 USF MAGNOLIA DRIVE  
TAMPA, FL 33612  
PHONE: 813-974-2201



## 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.

USF EYE INSTITUTE  
13127 USF Magnolia Drive.  
Tampa, FL 33612  
Phone: 813-974-2201  
Fax: 813-974-5621



APPOINTMENT: \_\_\_\_\_

TIME: \_\_\_\_\_

PROVIDER: \_\_\_\_\_

***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....)

RELATIONSHIP	EYE DISEASE	OTHER DISEASE

**REVIEW OF SYSTEMS: Please circle any that apply**

**General:**

Weight Loss/Gain  
Trouble falling asleep  
Fever  
Extreme Fatigue

**Allergic/Immunologic:**

Hay fever  
Immunodeficiency

**Respiratory:**

Chronic Cough  
Difficulty Breathing

**Cardiovascular:**

Chest Pain  
Abnormal feet swelling

**Skin:**

Rash  
Lump/Growth on skin

**Gastrointestinal:**

Frequent Heartburn  
Blood in Stool  
Stomach Ulcers

**Hematologic:**

Anemia  
Excessive Bleeding  
Blood Transfusion

**Psychiatric:**

Depression  
Anxiety  
Other \_\_\_\_\_

**Genitourinary:**

Painful Urination  
Blood in Urine

**Neurological:**

Seizures  
Numbness in arms/legs  
Weakness in arms/legs

**Head, Ear, Nose and Throat:**

Difficulty Hearing  
Buzzing/Ringing in the ears  
Difficulty Swallowing  
Frequent or severe headaches  
Tumors

**Endocrine:**

Excessive Thirst  
Hot/Cold Intolerance

**Musculoskeletal:**

Painful Joints  
Back Pain



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

**AFFIX PATIENT LABEL HERE**



**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)

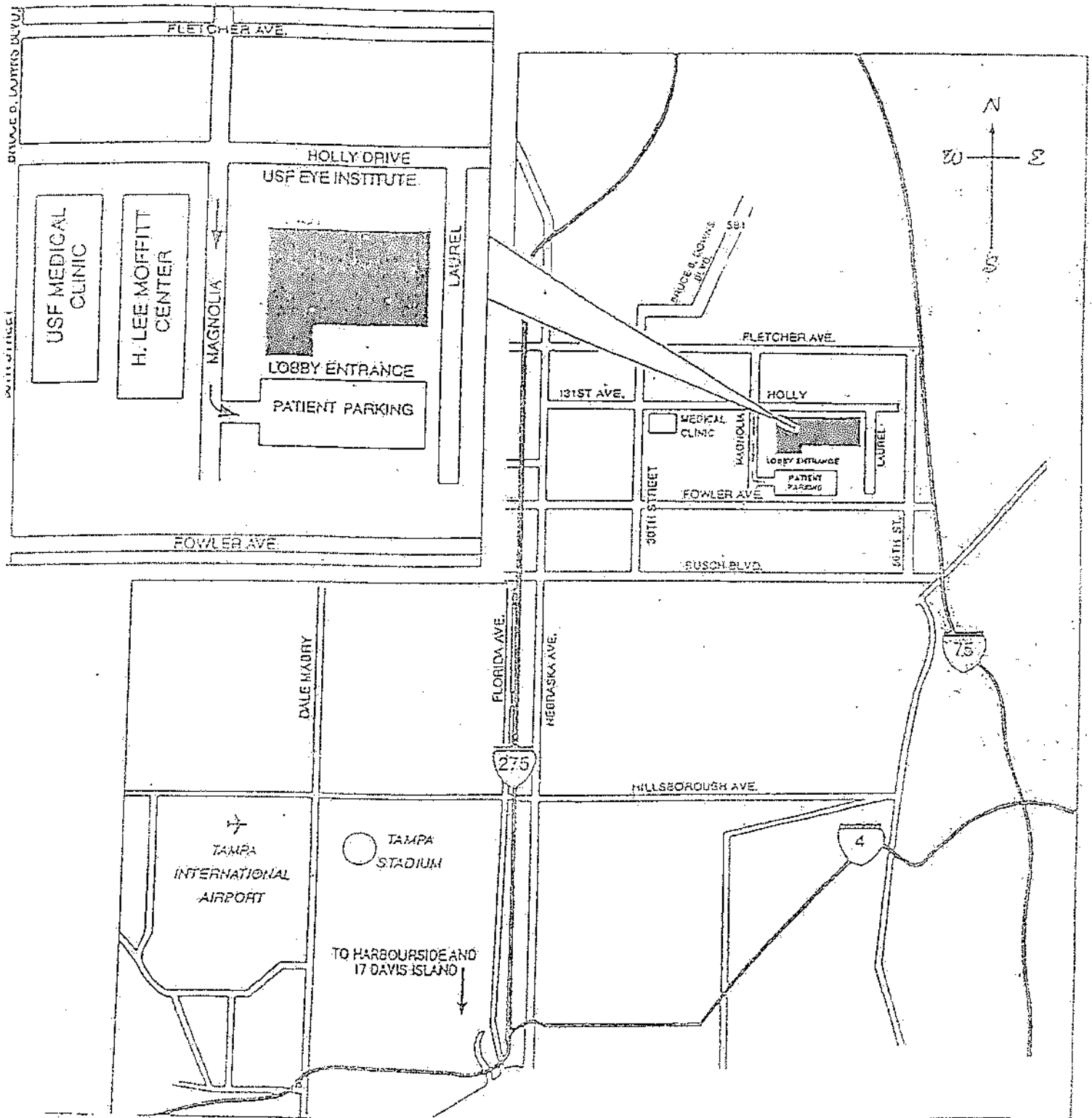
**Patient Refused to Sign**

\_\_\_\_\_  
(Signature of USF Health Rep)

\_\_\_\_\_  
Date

# UNIVERSITY OF SOUTH FLORIDA

## USF EYE INSTITUTE



Address: 13127 USF Magnolia Dr Tampa, FL 33612

(813)974-3820