CATARACT&EYE
Consultants of Michigan
By Midwest Vision Partners

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a section describing the rights to your medical information under the law. You ascertain that by your signature you have received or been offered our Notice of Privacy Practices that can be found on our website, http://www.eyeconsultantsofmich.com/.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to the use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you at any time.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Signature _____

Print Name _____

Date _____

Documentation of **failure** to obtain signed acknowledgement on _____, this acknowledgement of receipt of Notice of Privacy Practices was presented to _____ (the patient) and refused to provide a signature when requested.

MEDICAL HISTORY QUESTIONNAIRE Date: _____

CATARACT&EYE Consultants of Michigan By Midwest Vision Partners

Name: _____ DOB: _____

☐ Male ☐ Female ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Referring /Specialty Dr._____ Location (street & city) _____

Primary Care Physician: _____ Location (street & city) _____

Pharmacy:_____ Location (street & city) _____

Current Eye Conditions (Check all that apply)

☐Blurred vision ☐Fluctuating vision ☐Loss of side vision
☐Double vision ☐Hard to Focus ☐Glare/light sensitivity/halos
☐Mucous discharge ☐Redness ☐Eye trauma
☐Sandy or gritty feeling ☐Itching ☐Burning
☐Distorted vision ☐Drooping eyelid ☐Excess tearing or watering
☐Eye pain or soreness ☐Tired eyes, fatigue ☐Floaters
☐Flashing lights ☐Infection of eye or lid lump

Other _____

Past Ocular History: (Please mark all that apply) ☐ No history of eye problems

Do you wear contact lenses? ☐ No ☐ Yes Type_____

☐ Amblyopia (Lazy eye) ☐ Aphakia ☐ Cataracts
☐ Diabetic Retinopathy ☐ Dry Eyes ☐ Glaucoma
☐ Keratoconus ☐ Macular Degeneration ☐ Optic Neuritis
☐ Retinal Detachment ☐ Other _____

Have you ever taken Flomax? ☐ No ☐ Yes **Are you pregnant or nursing?** ☐ No ☐ Yes

If diabetic, last H1C with date: _____

Current Eye Medications: (Please list dosage and frequency)

_____ _____ _____

_____ _____ _____

Other Medical History: ☐ No history of illnesses

☐ Alzheimer's ☐Anemia ☐ Arrhythmia
☐ Arthritis ☐Asthma ☐ Bleeding Disorder
☐ Cancer Type: _____ ☐ Chicken Pox
☐ Congestive Heart Failure ☐ COPD ☐ Eczema
☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Hearing Loss
☐ Fibromyalgia ☐ Headache ☐ Heart Attack/Disease
☐ Hepatitis A / B / C ☐ Herpes Simplex ☐ Herpes Zoster / Shingles
☐ High Blood Pressure ☐ High Cholesterol ☐ Histoplasmosis
☐ HIV/ AIDS ☐ Kidney Disease ☐ Kidney Stones
☐ Liver Disease ☐ Lung Disease ☐ Lupus
☐ Meningitis ☐ Migraine ☐ MRSA
☐ Polymyalgia ☐ Psychiatric Disorder ☐ Skin Cancer
☐ Stroke ☐ Syphilis ☐ Thyroid Disease
☐ Toxoplasmosis ☐ Wound Infection ☐ Memory Loss

Other_____

Name _____

Ocular Surgeries: (Please mark all that apply) ☐ No prior ocular surgery

R - L		R - L		R - L	
☐	☐ Foreign Body Removal	☐	☐ Punctal Plugs	☐	☐ Cataract Surgery
☐	☐ Blepharoplasty	☐	☐ Retinal Surgery	☐	☐ RK
☐	☐ LASIK	☐	☐ PRK	☐	☐ Strabismus Surgery
☐	☐ Corneal Transplant	Other _____			

General Surgeries / Operations: (Please list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

All Other Medications: (Please list dosage and frequency) Including supplements

_____ _____ _____

_____ _____ _____

_____ _____ _____

Drug Allergies:	**Reaction**	**Severity**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

☐ **No known drug allergies**

Family History: **(Check family association)**

	Mother	Father	Grandmother	Grandfather	Aunt	Uncle
Arthritis, Lupus, or Autoimmune Diseases	_____	_____	_____	_____	_____	_____
Blindness	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Cataracts	_____	_____	_____	_____	_____	_____
COPD	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
Lazy Eye	_____	_____	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____	_____	_____
Retinal Disease	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____

Other _____

Name _____

Social History: (Please mark all that apply)

Smoking: ☐ Never smoked ☐ Former smoker ☐ Current some day smoker

☐ Current every day smoker ☐ Vaping ☐ Chewing Tobacco

Alcohol Use: ☐ Yes ☐No If yes, how much and how often?

_____

Recreational Drug Use: ☐ Yes ☐No If yes, what and how often?

_____

Review of Systems: (Please mark all that apply)

Head, Ears, Nose, and Throat
☐ Hard of Hearing
☐ Ringing in Ears
☐ Dizziness
☐ Swollen Glands

Gastrointestinal
☐ Heartburn
☐ Nausea
☐ Vomiting
☐ Jaundice or Yellow Skin
☐ Hepatitis

Hematology/Oncology
☐ Easy Bruising
☐ Prolonged Bleeding
☐ Blood Thinners

Allergy/ Immunologic
☐ Itching
☐ Seasonal Allergies
☐ Autoimmune Disease
☐ Immune Deficiency

Genitourinary
☐ Pain/burning while urinating
☐ Difficulty with Urination
☐ Blood in Urine
☐ History of Kidney Stones
☐ Sexually Transmitted Disease

Musculoskeletal
☐ Stiffness
☐ Arthritis
☐ Painful or Swollen Joints

Cardiovascular
☐ Chest Pain
Shortness of Breath
☐ Irregular Heartbeat
☐ Ankle Swelling

Psychiatric
☐ Anxiety
☐ Depression
☐ Mood Swings
☐ Difficulty Sleeping

Integumentary
☐ Rashes
☐ Skin Sores
☐ Hives
☐ Eczema

Constitutional
☐ Fatigue
☐ Weakness
☐ Fever
☐ Weight Gain
☐ Weight Loss

Endocrine
☐ Excess Thirst
☐ Always Hunger
☐ Excessive Urination
☐ Excessive Sweating

Neurological
☐ Seizures or Convulsions
☐ Weakness
☐ Paralysis
☐ Numbness or Tingling in Body
☐ Tremors
☐ Memory Loss

Respiratory
☐ Cough
☐ Congestion
☐ Wheezing
☐ Asthma
☐ Wheezing

Patient Signature _____ Date _____