PATIENT HISTORY FORM

OCLI VISION

ocli.net | 1-833-509-OCLI (1-833-509-6254)

What To Expect At Your Neuro-Ophthalmology Visit

The Neuro-Ophthalmology Team and your Neuro-Ophthalmologist welcome you to OCLI Vision. Our goal is to give each patient the time they deserve and to deliver compassionate, high-quality care.

Neuro-Ophthalmology visits are in-depth evaluations, with a focus on obtaining a detailed history of your symptoms and extensive examinations of the ophthalmic and neurologic systems. Visits include several different sessions with your Neuro-Ophthalmologist, as well as with the certified ophthalmic technicians and ocular imaging specialists.

Patients should expect:

- To have their **eyes dilated** with dilating drops.
- To have **testing** which may include visual fields, fundus photography, and optical coherence tomography (OCT), all of which are painless and involve no contact with the eyes.
- Additional testing may be needed depending on the nature of the symptoms and the exam findings, including placing additional drops in the eyes.

It should be expected that a new or follow up visit may last three to four hours in duration.

As your eyes will be dilated, you should make arrangements for transportation home if needed.

Please **remember to bring the following important items**. Please do not assume that we have access to any records outside of the OCLI Vision system. It is the patient's responsibility to have any records forwarded from outside physicians:

- Your current glasses.
- Any **blood work and other test results** already obtained for your current symptoms.
- Any **CT scans, MRI scans** or other imaging studies obtained for your current symptoms. It is important to bring both the report of the radiologist and the actual images of the CT or MRI scan, on a CD.
- A complete list of your **current and recent medications**.
- A complete **medical and surgical history**.

PATIENT HISTORY FORM

OCLI VISION

ocli.net | 1-833-509-OCLI (1-833-509-6254)

Date:_____

Patient's name: _____ Date of birth: _____ Age: ____ Sex:____

Referred By: _____ Primary Physician: _____
(Full Name) (Full Name)

Phone: _____ List of doctors for correspondence: _____
(Preferred) (Full Name)

Medical History

Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, stroke, heart attack, arthritis, etc.)? If yes, please list and explain:

_____

Do you have any eyes diseases (e.g. glaucoma, optic nerve problems, lazy eye, macular degeneration, retinal detachment, double vision, etc.)? If yes, please list and explain:

_____

Have you ever been hospitalized? If yes, please list and explain:

_____

Do you take any medication? If yes, please list, including doses:

_____

Do you take any eye medications? If yes, please list, including doses:

_____

Do you have any food or drug allergies? If yes, please list:

_____

Review Of Systems:

Do you currently have any of the following symptoms or difficulties? If yes, please explain.
Fever, night sweats, weight loss/gain, fatigue, etc.?

_____

Ear, nose, or throat problems (e.g. hearing loss, sinus problems, sore throat, etc.)?

_____

Heart problems (e.g. chest pain, irregular heartbeat, etc.)?

_____

Respiratory problems (e.g. shortness of breath, cough, wheeze, etc.)?

_____

Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting, etc.)?

_____

Urinary problems (e.g. pain or discomfort, blood in urine, etc.)?

_____

Skin problems (e.g. rash, dryness, etc.)?

_____

Muscle or joint problems (e.g. muscle aches, joint pain, swelling, etc.)?

_____

Neurologic or nerve problems (e.g. numbness, weakness, thought/memory difficulty, headaches, etc.)?

_____

Psychiatric difficulty (e.g. depression, anxiety, sleep difficulty, etc.)?

_____

Patient Signature _____ Date _____ MD Reviewed _____ Date _____
(initials)