MIDWEST GLAUCOMA CENTER, PC

MILDRED M.G. OLIVIER, M.D., F.A.C.S.
GLAUCOMA SPECIALIST

First Name: _____ Last Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Best Telephone Number for Contact: _____
Alternate Contact Telephone Number: Cell: _____ Work: _____
Date of Birth: _____ Male: _____ Female: _____
Social Security# : _____ Marital Status: S M D W
Employer's Name: _____ Address: _____
Name of Spouse: _____ Spouse Date of Birth: _____
Email Address: _____
Are you personally responsible for payment of fees? Yes _____ No _____
If no, please provide the name of the responsible party:
Name: _____ Relationship: _____ Telephone#: _____

Primary Insurance Carrier: _____
Secondary Insurance Carrier: _____
List the persons we may contact in case of emergency: (spouse, children, sibling, etc.)
1. Name: _____ Contact# : _____

2. Name: _____ Contact#: _____
List the names of persons we are allowed to speak with on your behalf regarding your treatment.
1. _____ 2. _____
3. _____ 3. _____

AUTHORIZATION: The undersigned hereby authorizes the release of any information relating to claims for benefits submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself, and /or my dependents that I will be bound by this signature as though the undersigned had personally signed the particular form.

_____ _____
(Signature) **(Date)**

MEDICARE PATIENTS: Statement to Permit Payment of Medicare Benefits to Providers, Physicians and Patients I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished by me or in Midwest Glaucoma Center, P.C., including my physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or benefits for related services.

_____ _____
(Signature) **(Date)**
Print Name: _____ **Medicare Number:** _____

****** IF THERE IS ANY CHANGE IN THIS INFORMATION, IT IS YOUR RESPONSIBILITY TO CONTACT US IMMEDIATELY TO UPDATE YOUR RECORDS.********

MIDWEST GLAUCOMA CENTER, P.C.

MILDRED M.G. OLIVIER, M.D., F.A.C.S

Name of Patient: _____ Date of Birth _____

Please list the name, address and phone number of your primary care physician and/or other physicians involved in your care.

PCP: _____ PCP Phone: _____

Office Address: _____

_____

_____

Other

Name of Physician: _____

Office Phone Number: _____

Office Fax Number: (if available) _____

Office Address: _____

_____

Name of Physician: _____

Office Phone Number: _____

Office Fax Number: (if available) _____

Office Address: _____

_____

MIDWEST GLAUCOMA CENTER, P.C.

MILDRED M.G. OLIVIER, M.D., F.A.C.S

Name of Patient: _____ Date of Birth _____

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PCP: _____ PCP Phone: _____

Office Address: _____

_____

_____

Other

Name of Physician: _____

Office Phone Number: _____

Office Fax Number: (if available) _____

Office Address: _____

_____

Name of Physician: _____

Office Phone Number: _____

Office Fax Number: (if available) _____

Office Address: _____

_____

MIDWEST GLAUCOMA CENTER, P.C.
MILDRED M.G. OLIVIER, M.D., F.A.C.S.

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Birth Date:_____

Name of physician referring you:_____ Physician

Phone:_____

Physician Address:_____ Date of Last Eye Exam:_____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "YES" please provide information:

	YES	NO	EXPLANATION OF PROBLEM
Constitutional Symptoms			
Fever	[ ]	[ ]	_____
Weight Loss	[ ]	[ ]	_____
Other	[ ]	[ ]	_____
Eyes:			
Blurred vision	[ ]	[ ]	_____
Discharge	[ ]	[ ]	_____
Double Vision	[ ]	[ ]	_____
Droopy lid	[ ]	[ ]	_____
Dryness	[ ]	[ ]	_____
Flashes	[ ]	[ ]	_____
Floaters	[ ]	[ ]	_____
Foreign body sensation	[ ]	[ ]	_____
Glare	[ ]	[ ]	_____
Itching	[ ]	[ ]	_____
Loss of vision	[ ]	[ ]	_____
Metamorphopsia	[ ]	[ ]	_____
Pain	[ ]	[ ]	_____
Light Sensitivity	[ ]	[ ]	_____
Redness	[ ]	[ ]	_____
Side loss vision	[ ]	[ ]	_____
Chronic infection of eye or lid	[ ]	[ ]	_____
Sties, Chalazion	[ ]	[ ]	_____
Fluctuating visual acuity	[ ]	[ ]	_____
Tired eyes	[ ]	[ ]	_____
Tearing	[ ]	[ ]	_____

Ears, nose, mouth, throat	YES	NO	EXPLANATION OF PROBLEM
Sinus congestion	[ ]	[ ]	_____
Runny nose	[ ]	[ ]	_____
Post-nasal drip	[ ]	[ ]	

	YES	NO	EXPLANATION OF PROBLEM
Earaches	[ ]	[ ]	
Hearing Loss	[ ]	[ ]	
Infection	[ ]	[ ]	
Mouth Sores	[ ]	[ ]	
Pain	[ ]	[ ]	
Smell disturbance	[ ]	[ ]	
Tinnitus (ear ringing)	[ ]	[ ]	
Vertigo (dizziness)	[ ]	[ ]	
Other:			

Cardiovascular (heart/blood vessels)

Chest Pain	[ ]	[ ]	
Heart Failure	[ ]	[ ]	
Heart Murmur	[ ]	[ ]	
High blood pressure	[ ]	[ ]	
Irregular heart beat	[ ]	[ ]	
Palpitations	[ ]	[ ]	
Paroxysmal nocturnal	[ ]	[ ]	
Rheumatic fever	[ ]	[ ]	
Slow heart beat	[ ]	[ ]	
Swelling of feet	[ ]	[ ]	
Other:			

Respiratory (lungs/breathing)

Asthma	[ ]	[ ]	
Chronic Bronchitis	[ ]	[ ]	
Chronic cough	[ ]	[ ]	
Emphysema	[ ]	[ ]	
Pneumonia	[ ]	[ ]	
Short of breath	[ ]	[ ]	
Spitting up blood	[ ]	[ ]	
Sputum	[ ]	[ ]	
Tuberculosis	[ ]	[ ]	
Wheezing	[ ]	[ ]	
Other:			

Gastrointestinal (stomach/intestines)

Abdominal pain	[ ]	[ ]	
Black tarry stools	[ ]	[ ]	
Change in bowel movements	[ ]	[ ]	
Constipation	[ ]	[ ]	
Diarrhea	[ ]	[ ]	
Gastritis	[ ]	[ ]	
Heart burn	[ ]	[ ]	
Hemorrhoids	[ ]	[ ]	
Hepatitis	[ ]	[ ]	
Jaundice	[ ]	[ ]	
Loss of appetite	[ ]	[ ]	

Nausea	[ ]	[ ]	
Rectal Bleeding	[ ]	[ ]	
Trouble Swallowing	[ ]	[ ]	
Ulcers	[ ]	[ ]	
Vomiting	[ ]	[ ]	
Vomiting Blood	[ ]	[ ]	
Other:			

Genitourinary (genitals/kidney/bladder)

Blood in Urine	[ ]	[ ]	
Discharge	[ ]	[ ]	
Frequent urination	[ ]	[ ]	
Hesitancy	[ ]	[ ]	
Impotence	[ ]	[ ]	
Incontinence	[ ]	[ ]	
Urinary infections	[ ]	[ ]	
Kidney stones	[ ]	[ ]	
Pain	[ ]	[ ]	
Polyuria	[ ]	[ ]	
Sexual Difficulties	[ ]	[ ]	
Sexually transmitted disease	[ ]	[ ]	
Other:			

Musculoskeletal

Arthritis	[ ]	[ ]	
Decreased range of motion	[ ]	[ ]	
Joint pain	[ ]	[ ]	
Low back pain	[ ]	[ ]	
Muscle aches	[ ]	[ ]	
Muscle cramps	[ ]	[ ]	
Stiffness	[ ]	[ ]	
Swollen Joints	[ ]	[ ]	
Other:			

Integument (skin and/or breast)

Breast Cancer	[ ]	[ ]	
Dermatitis	[ ]	[ ]	
Dryness	[ ]	[ ]	
Eczema	[ ]	[ ]	
Hives	[ ]	[ ]	
Itching	[ ]	[ ]	
Loss of hair	[ ]	[ ]	
Masses	[ ]	[ ]	
Pigmented lesions	[ ]	[ ]	
Rashes	[ ]	[ ]	
Skin cancer/tumors	[ ]	[ ]	
Other:			

Neurological

Blackouts	[ ]	[ ]	
Headache	[ ]		

	YES	No	Explain
Numbness	[ ]	[ ]	
Paralysis	[ ]	[ ]	
Seizures	[ ]	[ ]	
Tingling	[ ]	[ ]	
Tremors	[ ]	[ ]	
Weakness	[ ]	[ ]	
Other:			

Psychiatric

Anxiety	[ ]	[ ]	
Depression	[ ]	[ ]	
Hallucinations	[ ]	[ ]	
Nervousness	[ ]	[ ]	
Other:			

Endocrine

Cold intolerance	[ ]	[ ]	
Diabetes	[ ]	[ ]	
Excessive hunger	[ ]	[ ]	
Excessive thirst	[ ]	[ ]	
Excessive urination	[ ]	[ ]	
Heat intolerance	[ ]	[ ]	
Hypoglycemia	[ ]	[ ]	
Thyroid problems	[ ]	[ ]	
Other:			

Hematological/Lymphatics

Anemia	[ ]	[ ]	
Easy bleeding	[ ]	[ ]	
Easy brusing	[ ]	[ ]	
Swollen glands	[ ]	[ ]	
Unusual bleeding	[ ]	[ ]	
Other:			

Allergic and immunologic

Hay fever	[ ]	[ ]	
Hives	[ ]	[ ]	
Rashes	[ ]	[ ]	
Seasonal Allergies	[ ]	[ ]	

PAST HISTORY

Birth History:

List any medications you take:

List all major illnesses and injuries you have had in the past:

List any surgeries you have had:

Past ocular history:

Other:

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes
Do you have allergies to any medications: [ ]YES [ ]NO
If YES, list medications:

FAMILY HISTORY

PLEASE ANSWERS THESE QUESTIONS AS THEY PERTAIN TO YOUR FAMILY HISTORY AND NOT ABOUT YOURSELF

DISEASES	YES	NO	EXPLANATION OF PROBLEM
Blindness	[ ]	[ ]	_____
Cataract	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Macular degeneration	[ ]	[ ]	_____
Retinal detachment	[ ]	[ ]	_____
Arthritis	[ ]	[ ]	_____
Cancer(what kind?)	[ ]	[ ]	_____
Diabetes	[ ]	[ ]	_____
Heart attacks	[ ]	[ ]	_____
High blood pressure	[ ]	[ ]	_____
Kidney disease	[ ]	[ ]	_____
Lupus	[ ]	[ ]	_____
Sjögren's Syndrome	[ ]	[ ]	_____
Stroke	[ ]	[ ]	_____
Thyroid disease	[ ]	[ ]	_____
Tuberculosis	[ ]	[ ]	_____
Other	[ ]	[ ]	_____

SOCIAL HISTORY

Current occupation: _____

Do you drive:	[ ]	[ ]	
Do you have visual difficulty when driving?	[ ]	[ ]	
Do you have a problem with night vision?	[ ]	[ ]	
Have you ever tried to wear contacts?	[ ]	[ ]	
Do you currently wear glasses?	[ ]	[ ]	
If YES, how long have you had the current pair?			_____
Do you drink alcohol?	[ ]	[ ]	
If YES, how many glasses a day?			_____
Do you smoke?	[ ]	[ ]	
If YES, how many packs a day?			_____
Have you ever had a blood transfusion?	[ ]	[ ]	
Have you ever been in contact with a person who had a sexually transmitted disease?	[ ]	[ ]	

History reviewed [ ]No changes [ ] Additions as noted above

Physician's signature: _____ Date: _____