Methodist® Eye Associates

6560 Fannin Street
Scurlock Tower
Suite 1840
Houston, TX 77030
713-441-8823
713-441-6463 Fax

Dear Patient,

Thank you for choosing Methodist Eye Associates. I'm honored to be able to participate in your care and look forward to visiting with you soon.

Our clinic office is located in the Scurlock Tower at 6560 Fannin, Suite 1840.

Please fill out the attached patient questionnaire and bring it with you to your visit.

It is important for you to provide me with any past medical records that relate to your eyes. I will need--

- any imaging studies (e.g., MRI or CT scans) in advance (send or bring your films or CD)
- the reports of any visual field studies that have been done,
- copies of your records from the start of your neuro-ophthalmological problem including the names and records of your visits of all doctors you've seen.
- lab results
- admission and discharge records from other institutions.

Records can be mailed to us at 6560 Fannin, Suite 2100; or faxed to 713-441-6463.

If you have any questions, please don't hesitate to contact my office at 713-441-8823 and speak to my senior executive secretary Lin Cramer. Once again, thank you for your confidence.

Sincerely yours,

Andrew G. Lee, MD
Chair, Department of Ophthalmology, The Methodist Hospital
Professor of Ophthalmology, Weill Cornell Medical College
Clinical Professor, Department of Ophthalmology and Visual Sciences, UTMB Galveston
Adjunct Professor, Department of Ophthalmology, University of Iowa Hospitals & Clinics

PATIENT QUESTIONNAIRE

Andrew G. Lee, MD
Clinic address: 6560 Fannin Street, Suite 1840
Mailing address: 6560 Fannin Street, Suite 2100
Houston, TX 77030

Chair, Methodist Eye Associates
The Methodist Hospital
Professor of Ophthalmology
Weill Cornell Medical College

Patient Name: ________________________________

Date of visit: ________________________________

To my patient, I truly appreciate your helping me to help you better by providing the following information for us. I realize that this form may be long and a bit daunting but the more data that you can provide to us before the visit the more efficient and more effective the process will be on the date of your visit. Thanks for your patience and understanding and I look forward to serving you to the best of my abilities.

Some of this information we need in advance because it allows us to get your eye and medical records in advance and this will save you time and avoid unnecessary duplication of testing on the day of your visit.- Thanks,---*Andrew Lee MD*

If possible, could you bring this completed form with you (if you received it in advance by mail or fax) as well as (if possible) your medical records from all of the doctors who have seen you since your visual problem began and your laboratory testing and any head scans or other "x-rays" that you may have had (bringing the actual films or CD to us on your visit date is best if possible).

CHIEF COMPLAINT and HISTORY OF ILLNESS:

1. What is the main reason for today's visit?
   ____

1a. Circle all that apply
    Vision loss: one eye or both eyes
    Center vision loss or side vision loss or both
    Double vision
    Droopy eyelid
    Bulging eye
    Eye pain
    Headache

1b. Do you have any other complaints that you would like to address today as well?

    ____

2a. How long have you had this problem?

    ____

2b. When did your problem start? (date____________________)

3. How severe is your problem? Please circle one: 1 2 3 4 5 6 7 8 9 10
(1 = not severe or no symptoms 5 = moderate 10 = worst)

4. Is your problem getting better or worse over time?
Check one: ☐ better ☐ stable ☐ worse

5. How often does this problem occur?
Check one: ☐ constant ☐ comes and goes
How many episodes? _____ How often does it occur?______________________________

6. What makes it better? ____

7. What makes it worse? ____

8. What other symptoms are you having? ____

9. What is the name and address (if known) for your primary care doctor?

____

10. Please list any doctors who have seen you since your current visual problem began. Include as much information as you know, especially regarding any eye doctors (optometrists and ophthalmologists) you have seen. .

I saw Dr. _____________________________________(first and last name if known) who works at

__________________________________(practice location) on or about _______________(date).

I then saw Dr. _________________________________(first and last name if known) who works at

__________________________________(practice location) on or about _______________(date).

I also saw ____________________________________(first and last name if known) who works at

__________________________________(practice location) on or about _______________(date).

10a. Additional physicians seen:

____

10b. Did you have a visual field exam performed? Circle one: Yes No Don't know

10c. If you had a visual field exam performed, please list where__________________________

__________________________(doctor's office and location). When? ________________(Date)

11. Have you had a scan of your head recently? Circle one: Yes No

12. If you had a scan of your head, do you know if it was a CT (computed tomography) scan or MRI (magnetic resonance imaging) scan?

13. If you had a scan performed, can you list where ______________________________

(facility name and location) and when _______________________________(date)?

14. Did you have any other laboratory tests performed? If so, where ________________

____(facility name and location)

and when _______________(date) were the tests was performed?

*We would like to try and obtain your scan (actual digital or film copies) and scan reports if possible.

PAST MEDICAL HISTORY (please check any medical conditions you have):

- ☐ High Blood Pressure
- ☐ Asthma/Emphysema
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Renal (kidney) disease
- ☐ Kidney disease
- ☐ Stroke, mini-stroke
- ☐ Sinusitis
- ☐ Diabetes
- ☐ Heart Disease/Angina
- ☐ Peptic Ulcers
- ☐ Neck/Back disease
- ☐ Hepatitis/Liver Disease
- ☐ Thyroid Disease
- ☐ None of the above

PAST SURGICAL HISTORY (please check any surgeries you have had):

- ☐ Heart bypass/valve
- ☐ Gall bladder
- ☐ High Blood Pressure
- ☐ Coronary angioplasty
- ☐ Lung surgery
- ☐ Colon removal
- ☐ Carotid artery surgery
- ☐ Joint replacement
- ☐ Appendix removal
- ☐ Vascular bypass
- ☐ Back surgery
- ☐ Eye surgery
- ☐ Mastectomy
- ☐ Brain surgery
- ☐ Tonsillectomy
- ☐ Heart transplant
- ☐ Liver transplant
- ☐ Kidney transplant
- ☐ Other

EYE and OCULAR SURGICAL HISTORY (please list any EYE surgeries you have had):

Circle all that apply:

Cataract
Glaucoma
Diabetic retinopathy
Age-related macular degeneration
Ischemic optic neuropathy (“stroke in my eye”)
Giant cell arteritis
None

MEDICATIONS (List all your current medications and the dose you take):

Medication ______________________________________ Dose __________________________

Medication ______________________________________ Dose __________________________

Medication ______________________________________ Dose __________________________

Medication ______________________________________ Dose __________________________

Medication ______________________________________ Dose __________________________

Medication ______________________________________ Dose __________________________

Eye drops or ointment _____________________________ Dose __________________________

Vitamins ____ Dose __________________________

Herbal Supplements _______________________________ Dose __________________________

If applicable, erectile dysfunction agents (Viagra, Cialis, Levitra)___________________________

Have you taken corticosteroids (prednisone) within the past year? Yes No

ALLERGIES (medication/food allergies and allergic response):

Medication ____

Reaction ____

Food (shellfish, etc.) ____

Reaction ____

Other (IV contrast, etc.) ____

Reaction ____

☐ No known drug allergies

FAMILY HISTORY (Check all illnesses that run in your family):

☐ Vision loss ☐ Cancer ☐ Anesthesia reaction

☐ Alcoholism ☐ Sickle cell anemia ☐ Stroke

☐ Heart attack Others: ☐ Bleeding problems ☐ None of the above

☐ High blood pressure ☐ Diabetes

☐ Psychiatric illness ☐ Poor circulation

SOCIAL HISTORY:

Occupation ____

Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Domestic Partner

How many children do you have? ____

Have you ever smoked? ☐ Yes (☐ cigarettes ☐ cigar ☐ pipe) ☐ No

How much and for how long have you smoked? _________ packs per day for ______ years.

Quit? ☐Yes ☐No If yes, when did you quit? ________________

How much alcohol do you drink each day? ________________________________

List any elicit drugs you currently use: _____________________________________

Do you have any current or past drug addictions? ☐ Yes ☐ No

REVIEW OF SYSTEMS
(Check all symptoms you have had either now or in the past.)

Have you had cancer of any kind? ____yes _____no

If yes, what type______________________? What treatments were given ___________

____?

CONSTITUTIONAL:

☐ Weight loss _______ pounds in the past ____________ weeks.

☐ Fever, chills

☐ No concerns

NEUROLOGICAL:

☐ Stroke

☐ Ministroke

☐ Temporary loss of vision or speech control

☐ Loss of sensation

☐ Facial paralysis

☐ Paralysis of an arm or leg

☐ No concerns

EYES:

☐ Double Vision

☐ Loss of vision (Eye(s) affected? ☐ right eye ☐ left eye ☐ both eyes)

☐ Eye swelling

☐ Eye pain

☐ Other complaint ____

EARS, NOSE, THROAT:

☐ Hearing loss

☐ Sore throat

☐ Ear pain

☐ Dizziness

☐ No concerns

CARDIOVASCULAR/PULMONARY:

☐ Chest pain

☐ Heart Attack

☐ Irregular heartbeat

☐ Poor circulation

☐ Leg pain during walking

☐ Coughing up blood

☐ Shortness of breath ☐ Asthma ☐ No concerns

GASTROINTESTINAL:

☐ Stomach ulcers ☐ Blood in stool ☐ None of the above
☐ Nausea/vomiting ☐ Trouble swallowing
☐ Diarrhea/Constipation ☐ Abdominal pain

GENITOURINARY:

☐ Blood in urine ☐ Difficulty making urine
☐ Pain during urination ☐ None of the above

MUSCULOSKELETAL:

☐ Neck/Spine surgery ☐ Arthritis
☐ Neck or back disorder ☐ None of the above

SKIN:

☐ Skin cancers ☐ None
☐ Allergy to medical tape, iodine, or latex

PSYCHIATRIC:

☐ Clinical depression ☐ Anxiety ☐ None
☐ Schizophrenia ☐ Hallucinations
☐ Other psychiatric disorder (list) ____

INFECTIOUS DISEASE:

☐ Hepatitis ☐ Tuberculosis
☐ HIV/AIDS ☐ None

For Dr Lee's signature:

I have read and reviewed the comments and responses of this patient.

________________________________ ________________
Andrew G. Lee, MD Date