

**Robert N. Sieffert, OD**  
**522 College Ave.**  
**Clemson, SC 29631**

**V - 864.654.3685**  
**F - 864.654.3695**  
**mail@eyecareclemsn.com**

*Dear Patient,*

*Thank you for downloading and printing out our patient information and patient history forms. By completing and sending these information forms to our office in advance of your visit, we will be able to save you time during our information entry process. If you are unable to bring or send these completed forms in advance, please bring them with you to the office at the time of your scheduled appointment.*

*The completed forms can be faxed to our office @ 864 654-3695 or mailed to the above address.*

*Thank you for taking the time to review and fill out these necessary information forms. We look forward to providing for your eye care needs.*

*Sincerely,*

A handwritten signature in black ink that reads "Robert N. Sieffert, O.D." with a stylized flourish at the end.

**Robert N. Sieffert, O.D. and staff.**

# Welcome to the office of: Robert N. Sieffert, O.D.

Our records contain the following information. If there are changes, omissions, or errors please make corrections in the boxes under the highlighted text below.

<u>First Name</u>	<u>Mi</u>	<u>Last Name</u>
1		1
[ ]		
<u>Preferred Name</u>	<u>Birth</u>	<u>Mailing Address</u>
1		
[ ]	[ ]	[ ]
<u>Day Phone</u>	<u>Home Phone</u>	[ ]
[ ]	[ ]	[ ]
<u>Social Sec. #</u>		
[ ]	[ ]	[ ]
<u>Employer</u>	<u>Spouse Or Significant Other</u>	
[ ]	[ ]	

**If The Patient Is A Child:**

Parent's Name

[ ]

Parent's Address (if Different)

[ ]

[ ]

School Name Grade

[ ] [ ]

Teacher's Name  Mr.  Ms. [ ]

<u>Vision Insurance</u>	<u>Insured Name</u>
[ ]	[ ]
<u>Insurance Address</u>	<u>Group #</u> <u>Insured's Id</u>
[ ]	[ ] [ ]
[ ]	[ ]

Financially Responsible Party

[ ]

**How Did You Select Our Office?**

Referred By \_\_\_\_\_

Yellow Pages

Insurance Booklet

Family Has Been In

Other \_\_\_\_\_

<u>Medical Insurance</u>	<u>Group #</u>
[ ]	[ ]
<u>Insurance Address</u>	<u>Medical Insured Id #</u>
[ ]	[ ]
	<u>Insured Name</u>
[ ]	[ ]

**Please check your payment preference:**

Check  Charge Card  Cash

**Payment is expected at the time services are rendered, including non-covered portions of insurance.**

Please list your family physician's name & address.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I acknowledge that I have read and understand the OFFICE FINANCIAL POLICY for Robert N. Sieffert, O.D., (EYE CARE). I understand and agree that I am ultimately responsible for the balance of my account for any professional services and materials provided me.

DATE: \_\_\_\_\_ SIGNED: \_\_\_\_\_

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of insurance benefits either to myself or to Robert N. Sieffert, O.D. as assigned.

SIGNED: \_\_\_\_\_

I authorize payment of assigned government benefits to Robert N. Sieffert, O.D. for services and materials provided under his care.

SIGNED: \_\_\_\_\_

# Medical History Main Exam

Name   Age  Exam Date  Last Exam Date

Chief Complaint	Location	Onset	Frequency	Severity	Duration

**History of Present Illness**

**Currently taking medication(s)-(prescription and over-the-counter)**

1.  For  3.  For   
 2.  For  4.  For

Please list the type and date of eye surgeries you have had:

Drug Allergies  Yes  No If yes, list the medications :

List all major illnesses or injuries:

List any surgeries you have had:

Surgery Dates:

List your eye medications / Eye / Dosage


**Eye History:**

		<i>Please Describe Problem When Marked Yes</i>
<b>Do you generally have:</b>	<input type="radio"/> Yes <input type="radio"/> No	
Headache	<input type="radio"/> Yes <input type="radio"/> No	
Glare/Light Sensitivity	<input type="radio"/> Yes <input type="radio"/> No	
Tired Eyes	<input type="radio"/> Yes <input type="radio"/> No	
<b>Have you had problems with:</b>	<input type="radio"/> Yes <input type="radio"/> No	
Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No	
Burning	<input type="radio"/> Yes <input type="radio"/> No	
Dryness	<input type="radio"/> Yes <input type="radio"/> No	
Epiphora (Excess Tearing/Watering)	<input type="radio"/> Yes <input type="radio"/> No	
Eye Pain or Soreness	<input type="radio"/> Yes <input type="radio"/> No	
Foreign Body Sensation	<input type="radio"/> Yes <input type="radio"/> No	
Infection of Eye or Lid (blepharitis, stye)	<input type="radio"/> Yes <input type="radio"/> No	
Itching	<input type="radio"/> Yes <input type="radio"/> No	
Mucous Discharge	<input type="radio"/> Yes <input type="radio"/> No	
Ptosis (Drooping Eyelid)	<input type="radio"/> Yes <input type="radio"/> No	
Redness	<input type="radio"/> Yes <input type="radio"/> No	
Sandy or Gritty Feeling	<input type="radio"/> Yes <input type="radio"/> No	
Strabismus (Crossed Eyes)	<input type="radio"/> Yes <input type="radio"/> No	

		<i>Please Describe Problem When Marked Yes</i>
<b>Have you noticed problems with:</b>	<input type="radio"/> Yes <input type="radio"/> No	
Best Vision Blurred at Distance	<input type="radio"/> Yes <input type="radio"/> No	
Best Vision Blurred at Near	<input type="radio"/> Yes <input type="radio"/> No	
Distorted Vision (halos)	<input type="radio"/> Yes <input type="radio"/> No	
Double Vision	<input type="radio"/> Yes <input type="radio"/> No	
Floaters or Spots	<input type="radio"/> Yes <input type="radio"/> No	
Fluctuating Vision	<input type="radio"/> Yes <input type="radio"/> No	
Loss of Vision	<input type="radio"/> Yes <input type="radio"/> No	
Loss of Side Vision	<input type="radio"/> Yes <input type="radio"/> No	

## Medical History Main Exam

### Review of Systems

Name

Have you ever had problems with:

*Please Describe Problem When Marked Yes*

Fever	<input type="radio"/> Yes <input type="radio"/> No	
Weight Loss	<input type="radio"/> Yes <input type="radio"/> No	
Other Constitutional Symptoms	<input type="radio"/> Yes <input type="radio"/> No	
Ears, Nose, Throat	<input type="radio"/> Yes <input type="radio"/> No	
Cardiovascular (Heart, vessels, etc.)	<input type="radio"/> Yes <input type="radio"/> No	
Respiratory (Asthma, emphysema, etc.)	<input type="radio"/> Yes <input type="radio"/> No	
Gastrointestinal	<input type="radio"/> Yes <input type="radio"/> No	
Genital, Kidney, Bladder	<input type="radio"/> Yes <input type="radio"/> No	
Muscles, Bones, Joints (Arthritis, etc.)	<input type="radio"/> Yes <input type="radio"/> No	
Skin (Acne, warts, skin cancer, etc.)	<input type="radio"/> Yes <input type="radio"/> No	
Neurological (Multiple sclerosis, etc.)	<input type="radio"/> Yes <input type="radio"/> No	
Psychiatric (Anxiety, depression, insomnia)	<input type="radio"/> Yes <input type="radio"/> No	
Endocrine (Diabetes, hypothyroid, etc.)	<input type="radio"/> Yes <input type="radio"/> No	
Blood/Lymph (cholesterol, anemia, etc.)	<input type="radio"/> Yes <input type="radio"/> No	
Allergic/Immunologic (Hay fever, lupus, etc.)	<input type="radio"/> Yes <input type="radio"/> No	
Currently pregnant / breast feeding	<input type="radio"/> Yes <input type="radio"/> No	
<input style="width: 100%;" type="text"/>		
<input style="width: 100%;" type="text"/>		
<input style="width: 100%;" type="text"/>		
<input style="width: 100%;" type="text"/>		

### Family History

#### Eye Symptoms

	<input type="radio"/> Yes <input type="radio"/> No	<i>Please Describe Problem When Marked Yes</i>		Relationship to Patient
Amblyopia (Lazy Eye)	<input type="radio"/> Yes <input type="radio"/> No			
Blindness	<input type="radio"/> Yes <input type="radio"/> No			
Cataract(s)	<input type="radio"/> Yes <input type="radio"/> No			
Color Blindness	<input type="radio"/> Yes <input type="radio"/> No			
Glaucoma	<input type="radio"/> Yes <input type="radio"/> No			
Macular Degeneration	<input type="radio"/> Yes <input type="radio"/> No			
Retinal Detachment	<input type="radio"/> Yes <input type="radio"/> No			
Strabismus (Eye Turn)	<input type="radio"/> Yes <input type="radio"/> No			

#### Systemic Symptoms

	<input type="radio"/> Yes <input type="radio"/> No	<i>Please Describe Problem When Marked Yes</i>		Relationship to Patient
Arthritis	<input type="radio"/> Yes <input type="radio"/> No			
Cancer	<input type="radio"/> Yes <input type="radio"/> No			
Diabetes	<input type="radio"/> Yes <input type="radio"/> No			
Heart Disease	<input type="radio"/> Yes <input type="radio"/> No			
High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No			
Kidney Disease	<input type="radio"/> Yes <input type="radio"/> No			
Lupus	<input type="radio"/> Yes <input type="radio"/> No			
Stroke / A I Disease	<input type="radio"/> Yes <input type="radio"/> No			
Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No			
Other	<input type="radio"/> Yes <input type="radio"/> No			

# Medical History Main Exam

## Social History

Name

Current Occupation:  Grade  School   
Years  Employer

Computer Used  Yes  No Hrs per day

Distance from Desk  Distance from Computer

Do you drive?  Yes  No Mileage to work each way  Mileage at work

Do you have visual difficulty when driving?  Yes  No Do you have glare problems?  Yes  No

Do you have problems with night vision?  Yes  No

Have you ever tried to wear contact lenses?  Yes  No Reason for stopping

Do you currently wear contact lenses?  Yes  No Since

How many hours/day?  How many days/week?

Do you currently wear glasses?  Yes  No Since   Full Time  Part Time  Distance  Close

Glasses Owned  Single Vision  Trifocals  Safety Glasses  Progressive  
 Bifocals  Back-up Glasses  Sports Glasses  Other...

Have you had trouble in the past with glasses?  Yes  No

Have you had trouble in the past with Bifocals?  Yes  No

Do you wear sunglasses?  Yes  No

Are your sunglasses your current prescription?  Yes  No

Do you drink alcohol?  No  Occasional  1 per day  2-3/day  4+/day

Do you smoke?  No  Occasional  1/2 pack/day  1 pack/day  1+ pack

Race

History Reviewed  No Changes  Additions as noted above

Previous eye doctor?

Last History Date

### For office use only:

Initials

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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