Dr. Amy K. Boscia, OD
414 E. Upland Rd. Ste A
Ithaca, NY 14850
607-257-1500
F: 607-257-1501
www.ithacaeyecare.com

Name: _____ ***Date:*** _____

Address:_____

Dear _____,

Thank you for scheduling an appointment at Ithaca Eye Care with Dr. Amy Boscia on _____at _____AM/PM for a Neuro-Visual Medical Exam. We look forward to your visit!

Enclosed you will find our patient forms/ questionnaires. **The forms must be filled out, in entirety, prior to your appointment. (NO EXCEPTIONS)** If you feel you may be unable to complete the forms due to visual difficulty, please call our office, prior to your visit and a staff member would be happy to help you. It is also encouraged to bring the forms to our office in advanced in preparation for your appointment. They can be either dropped off at our 414 E. Upland location or sent via our secure patient portal. (please contact the office for details on our patient portal)

As you are aware, we are dedicated to the treatment of the whole patient, not just the condition. When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients, including time for a one-on-one consultation. When a patient fails to show up for an appointment, or not cancel in advance, our valuable resources are idle. More importantly, a patient care opportunity is missed.

We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances or a scheduling conflict beyond his or her control. In this event, we ask that you call our office and cancel your appointment **within 72 hours** of the scheduled visit. This courtesy allows our office staff to schedule another patient who is also in need of medical care. For your convenience, you may reschedule an appointment by calling 607-257-1500, emailing our office at ithacaeyecare@gmail.com or through the patient portal option on our website ithacaeyecare.com. **There is a $60.00 charge for patient who do not comply with our scheduling policies.**

When you arrive for your appointment please bring all of your insurance card(s), including any vision and medical insurance cards. Please bring all prescription eyewear you may have, including sunglasses, computer glasses, or glasses used for hobbies/sports. If you are a contact lens wearer, please bring your current contact lenses, the lens boxes or a copy of your contact lens prescription. Note this is different than your eyeglass prescription. In addition, you may also bring any previous health history records that may be relevant to your current condition

We look forward to seeing you soon. Again, we are committed to providing the best care possible, and to answering any questions regarding your health and well-being. Please feel free to call us at 607-257-1500.

Sincerely,
Dr. Amy K. Boscia and Ithaca Eye Care staff

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Authorization of Release of Health Information and Records:

I hereby authorize the release of my protected health information and records (including, if applicable, the release of information about substance abuse treatment, mental health service and HIV infection or AIDS). I understand this authorization is voluntary. I understand that any and all records, whether electronic, written or oral format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand a fax copy of this authorization is as valid as the original.

RECORDS TO BE DISCLOSED AND RELEASED FROM:

Doctor's Name_____ Doctor's Phone:_____
Doctor's Address_____ Doctor's Fax: _____
_____
_____

Patient Name:_____ Patient's Date of Birth:_____
Patient Address:_____ Patient's Phone Number:_____
_____
_____

Description of information to be released: All records including Exam Writer records and billing records

RECORDS TO BE RELEASED TO:

Ithaca Eye Care Optometry
Attn: Dr. Amy Boscia, OD
414 E. Upland Rd. Suite A Ithaca NY 14850
Phone: 607-257-1500
Fax: 607-257-1501

I understand that I can revoke this authorization at any time by notifying the office in writing. I also understand the revocation does not apply to information already released in response to this authorization. I have read and understand this form.

Patient Name:_____Date:_____
Patient Signature:_____

If patient is a minor, or you are signing as a representative or guardian of the patient, please sign below:

Print Name:_____Relationship to patient:_____
Representative/Guardian signature:_____

ITHACA EYECARE OPTOMETRY

Health History Questionnaire

Name:_____ **DOB:**___/___/____

*Address :*_____

Phone: _____ *Email:*_____

Reason for visit: _____

_____

Please record any symptoms you may be experiencing or specific concerns that you have about your eyes/ vision:

Have you ever been diagnosed with the following? On an average day, how much are you bothered by the symptoms listed below? (Rate each symptom from 0 to 10, where 10 is the worst it could be, and where 0 means you have none of that symptom)

Dizziness	/10
Nausea	/10
Anxiety	/10
Headache	/10
Neck ache	/10
Unsteady with walking	/10
Sensitivity to light	/10
Reading difficulty	/10

Have you ever been diagnosed with the following?

head injury/ concussion?	Y / N
Lazy eye?	Y / N
Reading difficulty?	Y / N
Have you ever had an operation? If so what was if for:_____	Y / N

(*Check all that apply)*

Have you ever been diagnosed with the following conditions?

Condition	Y	N
Cataracts		
Age-related Macular Degeneration		
Glaucoma		
Diabetes		
Diabetic Retinopathy		
Dry Eye		
Eye Infection, inflammation or allergy		
Floaters and/or flashes of light		
Iritis or Uveitis		
Retinal defects or degenerations		
Lazy eye/ Amblyopia		
Other:		
Double vision		

Review of Systems (please circle those that apply)

Constitutional	Fatigue, weight loss, Cancer
Ear, nose, throat	Hearing loss, sinusitis, dry mouth
Neurological	Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor, Migraine, Autism
Psychiatric	Depression, Attention deficit, anxiety disorder, bipolar disorder
Cardiovascular	Hypertension, Stoke/ CVA, heart disease, Vascular disease, Congestive heart failure
Respiratory	Asthma, bronchitis, Emphysema, Chronic Obstruction, Sleep apnea
Gastrointestinal	Crohn's disease, colitis, ulcer, acid reflux, celiac disease
Genitourinary	Kidney disease, Prostate disease/cancer, STD, Pregnant, nursing
Musculoskeletal	Arthritis, Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Osteoporosis, Gout
Integumentary	Eczema, Rosascea, Psoriasis, Herpes Simplex, Herpes Zoster/Shingles
Endocrine	Type 2 Diabetes Mellitus, Type 1 Diabetes Mellitus, Thyroid, Hormonal dysfunction
Heme/ Lymph	Anemia, Hypercholesteremia
Allergy/Immune	Environmental allergies, Rheumatoid Arthritis, Lupus, Sjogren's syndrome
Other	

Please list all medications: (oral and/or eye drops)

Medication	**Dosage**	**For**

Allergies to medication

Social History

Current Occupation:
Hobbies:
Do you drink? Y / N If yes how much? ___/ wk
Do you smoke? Y / N If yes how much? ___/ day
Former smoker? Y/ N

Family History

Condition	Y	N	Who
Cancer type:			
Diabetes Mellitus			
Hypertension			
Hyperthyroid			
Hypothyroid			
Cataracts			
Macular Degeneration			
Glaucoma			

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Sound Sensitivity Questionnaire

Name: _____ Date: _____

Instructions: Mark the box corresponding to the answer which best applies to you.	No	Yes, a little	Yes, quite a bit	Yes, a lot
1. Do you ever use earplugs or earmuffs to reduce your noise perception (Do not consider the use of hearing protection during abnormally high noise exposure situations)?				
2. Do you find it harder to ignore sounds around you in everyday situations?				
3. Do you have trouble reading in a noisy or loud environment?				
4. Do you have trouble concentrating in noisy surroundings?				
5. Do you have difficulty listening to conversations in noisy places?				
6. Has anyone you know ever told you that you tolerate noise or certain kinds of sound badly?				
7. Are you particularly sensitive to or bothered by street noise?				
8. Do you find the noise unpleasant in certain social situations (e.g. night clubs, pubs or bars, concerts, firework displays, cocktail receptions)?				
9. When someone suggests doing something (going out, to the cinema, to a concert, etc.), do you immediately think about the noise you are going to have to put up with?				
10. Do you ever turn down an invitation or not go out because of the noise you would have to face?				
11. Do noises or particular sounds bother you more in a quiet place than in a slightly noisy room?				
12. Do stress and tiredness reduce your ability to concentrate in noise?				
13. Are you less able to concentrate in noise towards the end of the day?				
14. Do noise and certain sounds cause you stress and irritation?				

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Head Injury Vision Symptom Questionnaire

Patient Name:_____ Date: _____

Instructions: Please circle the item that best matches your symptoms today. Please rate each symptom. How often does each occur? (circle a number)

	Never	Seldom	Occasional	Frequently	Always
Eyesight Clarity					
Distance vision blurred (Not clear with or without lenses)	0	1	2	3	4
Near vision blurred (Not clear with or without lenses)	0	1	2	3	4
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Poor night vision / can't see well to drive at night	0	1	2	3	4
Visual Comfort					
Eye discomfort / sore eyes / eyestrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue (Very tired after using eyes all day)	0	1	2	3	4
Feel "pulling" around the eyes	0	1	2	3	4
Doubling					
Double vision (Especially when tired)	0	1	2	3	4
Have to close or cover one eye to see clearly	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
Dry Eyes					
Eyes feel "dry" and sting	0	1	2	3	4
"Stare" into space without blinking	0	1	2	3	4
Have to rub the eyes a lot	0	1	2	3	4

Patient Name:_____ Date: _____

Instructions: Please circle the item that best matches your symptoms today. Please rate each symptom. How often does each occur? (circle a number)

	Never	Seldom	Occasional	Frequently	Always
Light Sensitivity					
Normal indoor lighting is uncomfortable (Too much glare)	0	1	2	3	4
Outdoor light too bright (Have to use sunglasses)	0	1	2	3	4
Indoors fluorescent lighting is bothersome or annoying	0	1	2	3	4
Depth Perception					
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Poor handwriting (spacing, size, legibility)	0	1	2	3	4
Peripheral Vision					
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight ahead isn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4
Reading					
Short attention span/easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading and writing	0	1	2	3	4
Poor reading comprehension/can't remember what was read	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place/use finger not to lose place when reading	0	1	2	3	4