Medical History Questionnaire

Name	Social Security # (if we are billing insurance)	Today's Date
Address	Phone #	Birth Date
City, State, Zip	Marital Status Single/Married/Separated/Divorced/Widowed	Employment Status FT/PT/UE/Retired
Communication Preference Email, Traditional Postal Mail, Telephone	Email Address	Are You A Student Yes No Full/Part
Ancestry: American Indian or Alaska Native, Asian, African American, Caucasian, Hispanic, Native Hawaiian or Pacific Islander	Ethnicity: Hispanic or Latino, Native Hawaiian or Pacific Islander, Not Hispanic or Latino	Preferred Language English Spanish
Guarantor Name & Address (if different)	City, State, Zip	Date of Birth

Thank you for taking the time to carefully complete the patient health information form. The doctor will review this information, and all the information provided will be held in strict confidence.

Review of Systems Do you currently have or have you ever had **chronic** problems in the following areas? Please check only those that apply to you.

System	Yes	?	System	Yes	?
CONSTITUTIONAL			**EARS, NOSE, MOUTH, THROAT**		
Fever			Allergies or Hay Fever		
Weight loss/gain			Sinus Congestion		
INTEGUMENTARY (skin)			Runny Nose		
Skin Cancer			Post-Nasal Drip		
NEUROLOGICAL			Chronic Cough		
Headaches			Dry Throat or Mouth		
Migraines			Ringing In Ears		
Seizures			Ear Pain or Infection		
EYES			Deaf		
Loss of Vision			**CARDIOVASCULAR/VASCULAR**		
Blurred Vision			Heart Disease		
Distorted Vision / Halos			High Blood Pressure		
Loss of Peripheral Vision			High Cholesterol		
Double Vision			**GASTROINTESTINAL**		
Dryness			Diarrhea		
Mucous Discharge			Constipation		
Redness: Some Extreme			**GENITOURINARY**		
Itching: Some Extreme			Genital / Kidney / Bladder		
Burning: Some Extreme			**MUSCULOSKELETAL**		
Foreign Body Sensation			Rheumatoid Arthritis		
Excess Tearing or Watering			Muscle		
Glare or Light Sensitivity			Joint Pain		
Eye Pain or Soreness			**HEMATOLOGIC / LYMPHATIC**		
Chronic Infections			Anemia		
Sties or Chalazion			Bleeding Problems		
Flashes			**IMMUNOLOGIC**		
Floaters			Influenza / Viral Infections		
Tired Eyes			**PSYCHIATRIC**		
RESPIRATORY			Depression		
Asthma			Anxiety		
Chronic Bronchitis			**ENDOCRINE**		
Emphysema			Thyroid or Other Glands		
Sleep Apnea			Diabetes		

If you answered **YES** to any of the above or have a condition(s) not listed, please briefly explain:

Family Medical & Ocular History

Please note any family members with the following conditions:

Condition	Yes	Unsure	Relationship to You
Blindness			
Cataract			
Glaucoma			
Crossed or Lazy Eye			
Macular Degeneration			
Retinal Disease			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			

Medical History

List any **allergies** including medications: _____

List any medications you take (oral contraceptives, aspirin, over the counter, vitamins, medical marijuana etc):

List all major injuries, surgeries, and/or hospitalizations you have had and approximately when: _____

Are you pregnant or nursing? If yes, list due date or delivery date: _____

Ocular History

List any ocular surgeries/injuries, approximately when and which eye: _____

Have you have or had any of the following:

	Yes	No		Yes	No		Yes	No
Prominent Eyes			Cross Eyes			Lazy Eye		
Eye Infection			Retinal Disease			Glaucoma		
Cataracts			Eye Injury			Drooping Eyes		

Other please list: _____

Have you had your eyes dilated? Yes No
If yes, were there any problems? Yes No
Do you wear glasses? Yes No
* Approximate age of glasses ____yr(s) old
* Are you planning on new glasses?
Yes No Only if Rx changes
* Lens: Single, Bifocal, Trifocal, Progressive

Approximate date of your last complete eye exam: _____
Have you worn contacts prior to today's exam? Yes No
* If yes are they comfortable?Yes No
* Replacement schedule: daily, bi-weekly, monthly, or other
* What type of lenses? Soft, RGP, Toric, Bifocal or Multifocal
* How old is you current pair of lenses? _____
* Any favorite solution or cleaner? _____

Social History

What is your occupation/who is your employer?_____
Do you drive? Yes No * If yes, any visual difficulties when driving? Yes No
* If yes, please explain: _____
Do you use a computer? Yes No
* If yes, how many hours per day average? _____
* Any difficulties with computer vision? Yes No
* If yes, please explain: _____
Do you use tobacco products? Yes No If yes, type/amount/ how long: _____
Do you use alcohol? Yes No If yes, type/amount/ how long: _____
Do you use illegal drugs? Yes No If yes, type/amount/how long: _____
Have you ever been exposed to or infected with Hepatitis, HIV/AIDS, or TB? Yes No

EYE CARE SERVICES

Patient Acknowledgment
Notice of Privacy Practices

I, _____ acknowledge that I have received a copy of Notice of Privacy Practices from Marc Austhof, OD. I have been given the opportunity to ask any question I may have regarding this notice.

_____

Signature

_____

Date

***Insurance Authorization ***

Authorization to pay benefits to physician: I hereby authorize payment directly to the doctor for benefits otherwise payable to me for services rendered. I understand that I am responsible for the balance of fees not paid by insurance.

_____

Signature

Member
American Optometric Association

Effective date of notice: April 14, 2003

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, [we will] [we usually will not] ask you for special written permission.

[We will ask for special written permission in the following situations: _____.]

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.