EYE CARE OF SAN DIEGO

Please Print

Patient Name_____
Last **First** **Middle**

Address_____
Street **Apt #** **City** **State** **Zip**

Date of Birth_____Gender_____

Home Phone_____Cell Phone_____

Work Phone_____Social Security#_____

E-mail_____

Occupation_____Employer_____

Spouse's Name_____Phone_____

Referred By_____Phone_____

Primary Physician:

Name_____Phone#_____

Whom to Notify in Case of Emergency:

Name_____ Phone#_____

Relationship to Patient_____

Insurance: Please list all healthcare insurance companies which cover this patient:

Primary Insurance_____Policy#_____Insured_____

Secondary Insurance_____Policy#_____Insured_____

Medicare#_____Medi-cal#_____

PLEASE READ AND SIGN THE FOLLOWING:

I HEREBY AUTHORIZE EYE CARE OF SAN DIEGO TO FURNISH INFORMATION TO MY INSURANCE COMPANY CONCERNING MY PRESENT ILLNESS OR INJURY. I HEREBY ASSIGN EYE CARE OF SAN DIEGO ALL INSURANCE BENEFITS TO WHICH I AM ENTITLED FOR SERVICES. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND/OR ALL FEES NOT COVERED BY MY INSURANCE PLAN.

Signature_____Date_____

MEDICAL HISTORY QUESTIONNAIRE
(Please answer ALL questions)

Name _____ Date _____

Date of **birth** _____ Date of **last eye examination** _____

Reason for today's visit _____

PERSONAL MEDICAL HISTORY (Check all that apply)

Allergic/Immunologic: ☐Seasonal allergies ☐Lupus ☐Sjogren's Other:_____

Cardiovascular: ☐High Blood Pressure ☐Heart Attack Other:_____

Endocrine: ☐ Diabetes: Year Diagnosed_____ ☐Hyperthyroid ☐Hypothyroid Other:_____

Gastrointestinal: ☐Gastric Reflux Other:_____

Genitourinary: ☐Enlarged Prostate Other:_____

Hematologic/Lymphatic: ☐High Cholesterol ☐Anemia Other:_____

Skin: ☐Acne ☐Skin Cancer: List type/location_____ Other:_____

Neurological: ☐Stroke ☐Multiple Sclerosis ☐Concussion Other:_____

Musculoskeletal: ☐Arthritis ☐Fibromyalgia Other:_____

Psychiatric: ☐Depression ☐Anxiety ☐Insomnia Other:_____

Respiratory: ☐Asthma ☐COPD ☐Other:_____

Other medical conditions:_____

List ANY surgeries you have had on your body:_____

Previous **eye surgeries:** ☐Cataract: ☐right ☐left ☐PRK/Laser procedure: ☐right ☐left ☐NONE

Other:_____ Date(s) _____

FAMILY HISTORY M=Mother F=Father S=Sibling GP=Grandparent

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Macular degeneration			
Eye turn			
Cancer			
Diabetes			
Heart disease			
High blood pressure			
Other (ex. Thyroid, Arthritis)Specify_____			

MEDICATIONS

List **all medications** you currently take (prescription *and* **over the counter**) and eye drops:

_____

_____

_____

Have you ever taken Flomax? ☐YES ☐NO If YES, when?_____

Are you **allergic** to ANY medications? ☐YES ☐NO

If YES, list the medication(s) and reaction:_____

SOCIAL HISTORY

Education (high school, vocational school, college degree): _____

Marital Status (married, divorced, single, widowed): _____

Do you drive? ☐YES ☐NO Do you have visual difficulty when driving? ☐YES ☐NO

Do you currently wear contact lenses? ☐YES ☐NO If YES, how long_____

Do you currently wear glasses? ☐YES ☐NO If YES, how old is your current prescription?_____

Do you drink alcohol? ☐YES ☐NO If YES: ☐less than 1 per day ☐1-2 per day ☐3 or more per day

Do you smoke? ☐YES: ☐daily ☐some days ☐NEVER ☐Previous Smoker: When did you quit?_____

History of drug use? ☐YES ☐NO Have you ever had a blood transfusion? ☐YES ☐NO

Do you ***currently*** have any problems in the following areas? If **YES**, please provide information.

	YES	**NO**	**EXPLANATION OF PROBLEM**
Blurred vision			
Excess tearing/Watering			
Eye pain or soreness			
Redness			
Loss of vision / Loss of side vision			
Double vision / Diplopia			
Flashes & Floaters			
Weight loss (abnormal)			
Dry mouth			
Shortness of Breath			
Stiffness			
Headache			
Mucous discharge			
Distorted vision (halos)			
Sandy or gritty feeling / Dryness			
Itching			
Foreign body sensation			
Glare/light sensitivity			
Infection of eye or lid (blepharitis, stye)			
Crossed eyes, lazy eye			
Drooping eyelid			
Other (for example: glaucoma)			

EYE CARE OF SAN DIEGO

Acknowledgement of Receipt of Notice of Privacy Practices and Patient's Rights and Responsibilities

(To be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information. I have also been offered a copy of the Patient's Rights and Responsibilities policy.

Signed: _____ Date: _____

Relationship (if not signed by patient): _____

I wish to place the following restrictions on disclosure of my health information:

_____

Internal Use Only:

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

HIPAA RELEASE FORM

In accordance with HIPAA laws we need your authorization to speak with anyone by you with regards to your personal medical information. In the area below, please complete the information to let Eye Care of San Diego know how you would like us to handle your private medical information.

I, _____, give Eye Care of San Diego permission to speak with the following people regarding my personal medical information.

Name	Relationship

☐ Please check this box if you do not wish us to speak with anyone but you with regards to your personal medical information.

_____ _____

Patient Signature Date