

OCULAR AND MEDICAL HISTORY QUESTIONNAIRE

Name:		М	F	Date:	
Date of Birth:				Home Phone:	
Social Security #:				Work Phone:	
Address:				Cell Phone:	
City:	Zip:			Email:	
	- r <u></u>				
Please complete all personal and employm	ent info	rmation	:		
Driver's License #:				For whom do you work?	
Occupation:				Employer's Address:	
Spouse's Name:				City:	
Who referred you to our office?				Employer's Phone:	
Minor children living at home? Yes 🗖 🛛 N	0 🗆	lf ves. r	olease list	below:	
Name:	-	Age:		Name:	Age:
MEDICAL HISTORY					
Name of Medical Doctor:					
Do you have any allergies to medications?	Yes 🗖	No 🗆	lf yes, e	explain:	
	,				
List all major injuries, surgeries and/or illnes	sses you'	ve had:			
List any of the following that you have had:	crossed	eves laz	veve dro	ooning evelid prominent eves glauc	oma retinal disease
cataracts, eye infections or eye injury:		-			onna, retinar alocase,
Are you pregnant and/or nursing?					
VISUAL HISTORY					
	Yes 🛛	No 🗖	If ves. h	now old is your present pair of glasse	s?
	Yes 🗆	No 🗆	• •	now old is your present pair of sun gl	
	Yes 🗆	No 🗆		now old is your present pair of contac	
Type of contact lenses: Soft Disposable E					
FAMILY MEDICAL AND OCULAR HISTOF Please note any FAMILY HISTORY i.e. parent		rs childr	on grand	Inarents (nlease specify maternal/na	ternal) for the following:
					ternaly for the following.
DISEASE/CONDITION	YES	NO	?	RELATIONSHIP TO YOU	
Arthritis					
Blindness					
Cataract					
Crossed Eyes					
Diabetes					
Glaucoma					
Heart Disease					
High Blood Pressure					
Kidney Disease					
Lupus					
Macular Degeneration					
Retinal Detachment/Disease					
-	_			. <u>.</u>	
Thyroid Disease					
Other					

SOCIAL HISTORY (This information is kept confidential. You may discuss this portion directly with the doctor if you prefer.)

 $\hfill\square$ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive?	Yes 🛛	No 🗖	If yes, do you have visual difficulty when driving?	Yes 🛛	No 🗖	If yes, please describe:

Do you use tobacco products?	Yes 🛛	No 🗆	If yes, type/amount/how long:
Do you drink alcohol?	Yes 🛛	No 🗆	If yes, type/amount/how long:
Do you use illegal drugs?	Yes 🛛	No 🗆	If yes, type/amount/how long:

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

BORES/JOINTS/MUSCLES Blurred Vision		YES	NO	?		YES	NO	?
BurningMuscle PainCataractsRheumatoid ArthritisChronic Infection of Eye or LidCONSTITUTIONAL (Circle one)Crossed EyedFever, Weight Loss/GainDistorted Vision/HalosEARS, NOSE, MOUTH, THROATDouble Vision </td <td>OCULAR (Eyes)</td> <td></td> <td></td> <td></td> <td>BONES/JOINTS/MUSCLES</td> <td></td> <td></td> <td></td>	OCULAR (Eyes)				BONES/JOINTS/MUSCLES			
Cataracts Image: Construction of Eye or Lid Image: Construction Construction Carlos on Eyed Image: Construction Carlos o	Blurred Vision				Joint Pain			
Chronic Infection of Eye or Lid CONSTITUTIONAL (Circle one)	Burning				Muscle Pain			
Crossed EyedFever, Weight Loss/GainDistorted Vision/HalosEARS, NOSE, MOUTH, THROATDouble VisionSinus CongestionDrooping EyelidSinus CongestionDrynessRunny NoseExcess Tearing/WateringPost-Nasal DripEye InfectionsDry Throat/MouthEye Pain or SorenessDry Throat/MouthEye Pain or SorenessDiabetesGlarce/Light SensitivityGASTROINTESTINALGlaucomaDiarrhea </td <td>Cataracts</td> <td></td> <td></td> <td></td> <td>Rheumatoid Arthritis</td> <td></td> <td></td> <td></td>	Cataracts				Rheumatoid Arthritis			
Distorted Vision/Halos EARS, NOSE, MOUTH, THROAT Double Vision Allergies/Hay Fever Droping Eyelid Broping Eyelid Broping Eyelid Broping Eyelid Post-Nasal Drip Broping Eyelid Post-Nasal Drip Excess Tearing/Watering Post-Nasal Drip Eye Infections Chronic Cough Eye Infections Dry Throat/Mouth Dry Throat/Mouth Dry Throat/Mouth Eye Pain or Soreness Endocrine Flashes/Floaters in Vision Endocrine Foreign Body Sensation Thyroid/Other Glands Constipation Constipation Constipation Constipation Constipation Endocrine Constipation Integumentary (Sircle one) Constipation Endocrine Endocrine	Chronic Infection of Eye or Lid				CONSTITUTIONAL (Circle one)			
Double Vision Image: Construct of the second se	Crossed Eyed				Fever, Weight Loss/Gain			
Drooping EyelidSinus CongestionDrynessRunny NoseExcess Tearing/WateringPost-Nasal DripEye InfectionsDryntssEye InfectionsDryntroat/MouthEye InjuriesDryntroat/MouthEye InjuriesDryntroat/MouthEye InjuriesDryntroat/MouthEye Pain or SorenessDryntroat/MouthFlashes/Floaters in VisionDiabetesGlare/Light SensitivityGASTROINTESTINALGlaucomaDiabretsItchingConstipationLazy EyeGENITOURINARY (Circle one)Loss of VisionProminent EyesInstegumentare (Skin)Prominent EyesRetinal DiseaseCancerSandy or Gritty FeelingPSYCHIATRICStyes or ChalazionRESPIRATORYTired EyesAsthmaMigrainesMigrainesALLERGIC (other than Hay Fever)ALLERGIC (other than Hay Fever)IntegrationHigh Blood PressureIntegrateIntegrateIntegrateIntegrateIntegrateIntegrateIntegrateIntegrateIntegrateInte	Distorted Vision/Halos				EARS, NOSE, MOUTH, THROAT			
DrynessIRunny NoseIIExcess Tearing/WateringIPost-Nasal DripIIEye InfectionsIChronic CoughIIEye InjuriesIDry Throat/MouthIIEye Pain or SorenessIENDOCRINEIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Double Vision				Allergies/Hay Fever			
Excess Tearing/WateringImage: Construct of the second	Drooping Eyelid				Sinus Congestion			
Eye InfectionsImage: Construct of the second se	Dryness				Runny Nose			
Fye InjuriesImage: Constraint of the second sec	Excess Tearing/Watering				Post-Nasal Drip			
Eye Pain or Soreness ENDOCRINE Flashes/Floaters in Vision Diabetes Thyroid/Other Glands Glare/Light Sensitivity Glare/Light Sensitivity Diarrhea Diarrhea Constipation Constipation Genitals/Kidney/Bladder Constipation Const	Eye Infections				Chronic Cough			
Iashes/Floaters in VisionIIDiabetesIIForeign Body SensationIIThyroid/Other GlandsIIGlare/Light SensitivityIIGASTROINTESTINALIIGlaucomaIIDiarrheaIIIItchingIIIConstipationIIILazy EyeIIGENITOURINARY (Circle one)IIIIMucous DischargeIIGENITOURINARY (Skin)IIIIProminent EyesIIIIIIIIIRednessII <td>Eye Injuries</td> <td></td> <td></td> <td></td> <td>Dry Throat/Mouth</td> <td></td> <td></td> <td></td>	Eye Injuries				Dry Throat/Mouth			
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Lazy Eye GENITOURINARY (Circle one) Loss of Vision Genitals/Kidney/Bladder Image: Circle one) Mucous Discharge Image: Circle one) Image: Circle one) Mucous Discharge Image: Circle one) Image: Circle one) Prominent Eyes Image: Circle one) Image: Circle one) Prominent Eyes Image: Circle one) Image: Circle one) Redness Image: Circle one) Image: Circle one) Redness Image: Circle one) Image: Circle one) Retinal Disease Image: Circle one) Image: Circle one) Sandy or Gritty Feeling Image: Circle one) Image: Circle one) Styes or Chalazion Image: Circle one) Image: Circle one) Tired Eyes Image: Circle one) Image: Circle one) MEUROLOGICAL Image: Circle one) Image: Circle one) Migraines Image: Circle one) Image: Circle one) Image: Circle one) Migraines Image: Circle one) Image: Circle one) Image: Circle one) Seizures Image: Circle one) Image: Circle one) Image: Circle one) ALLERGIC (other than Hay Fever) Image: Circle one) Image	Glaucoma				Diarrhea			
Loss of VisionImage: Constant of Constant	Itching				•			
Mucous Discharge Image: Second Se	Lazy Eye	_						
Prominent Eyes Image: Constraint of the constraint of th	Loss of Vision							
Redness Image: Constant of the symbolic constant o	-	_						
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ALLERGIC (other than Hay Fever)	-				-	_	_	_
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IMMUNOLOGIC Image: Description of the second se					5			
	IMMUNOLOGIC	Ц			Vascular Disease			

List any medications you are currently taking (including oral contraceptives, aspirin, over the counter, home remedies). If you answered YES to any of the above or have a condition not listed, please explain:

Updated Date	Patient Initials	Doctor Initials
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//		
//		
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Receipt of Notice of Privacy Policies & Consent Form

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for processing claims or obtaining payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform healthcare operations. You also signify that you have received a copy of our **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Julie Gussenhoven, O.D.

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Print Name

Relationship to Patient

Source of Authority:



Notice of Privacy Practices

Effective date of notice: April 14, 2003

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule

We respect our legal obligation to keep health information that identifies you, private. The law obligates us to give you notice of our privacy practices.

Generally, we can only use your health information in our office or disclose it outside of our office, without your written permission, for purpose of treatment, payment or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

Examples of how we use information for treatment purpose:

- When we set up an appointment for you.
- When our technician or doctor tests your eyes.
- When the doctor prescribes glasses or contact lenses.
- When the doctor prescribes medication.
- When our staff helps you select and order glasses or contact lenses.
- When we show you low vision aids.

We may disclose your health information outside of our office for treatment purposes, for example:

- If we refer you to another doctor or clinic for eye care or low vision aids or services.
- If we send a prescription for glasses or contacts to another professional to be filled.
- When we provide a prescription for medication to a pharmacist.
- When we phone to let you know that your glasses or contact lenses are ready to be picked up.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for **payment** purposes. Some examples are:

- When our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services.
- When we prepare bills to send to you or your health or vision care plan.
- When we process payment by credit card and when we try to collect unpaid amounts due.
- When bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.
- You can ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to

ask for confidential communications, send a written request to Julie Gussenhoven, OD at the address, fax, or email shown at the beginning of this notice.

- You can ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of the time for use to give you access or photocopies if we sent you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to Julie Gussenhoven, OD at the address, fax, or e-mail shown at the beginning of this notice.
- You can ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to person who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to Julie Gussenhoven, OD at the address, fax, or e-mail shown at the beginning of this notice.
- You can get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by you, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to Julie Gussenhoven, OD at the address, fax, or e-mail shown at the beginning of this notice.

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, and have copies available in our office.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to Julie Gussenhoven, OD at the address, fax, or e-mail shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

For More Information

If you want more information about our privacy practices, call or visit Julie Gussenhoven, OD at the address or phone number shown at the beginning of this notice.