JULIE GUSSENHOVEN, OD
DOCTOR OF OPTOMETRY

OCULAR AND MEDICAL HISTORY QUESTIONNAIRE

Name: _____ M F Date: _____
Date of Birth: _____ Home Phone: _____
Social Security #: _____ Work Phone: _____
Address: _____ Cell Phone: _____ Text OK? Y☐ N☐
City: _____ Zip: _____ Email: _____

Please complete all personal and employment information:

Driver's License #: _____ For whom do you work? _____
Occupation: _____ Employer's Address: _____
Spouse's Name: _____ City: _____ Zip: _____
Who referred you to our office? _____ Employer's Phone: _____

Minor children living at home? Yes ☐ No ☐ If yes, please list below:

Name:	Age:	Name:	Age:
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY

Name of Medical Doctor: _____
Do you have any allergies to medications? Yes ☐ No ☐ If yes, explain: _____

List all major injuries, surgeries and/or illnesses you've had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____
Are you pregnant and/or nursing? Yes ☐ No ☐

VISUAL HISTORY

Do you wear glasses? Yes ☐ No ☐ If yes, how old is your present pair of glasses? _____
Do you wear sun glasses? Yes ☐ No ☐ If yes, how old is your present pair of sun glasses? _____
Do you wear contact lenses? Yes ☐ No ☐ If yes, how old is your present pair of contacts? _____
Type of contact lenses: Soft Disposable ☐ Soft Extended Wear ☐ Gas Permeable ☐ Are they comfortable? Yes ☐ No ☐

FAMILY MEDICAL AND OCULAR HISTORY

Please note any FAMILY HISTORY i.e. parents, siblings, children, grandparents (please specify maternal/paternal) 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	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other_____	☐	☐	☐	

PLEASE TURN OVER AND COMPLETE OTHER SIDE

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

☐ 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:

	YES	NO	?
OCULAR (Eyes)			
Blurred Vision	☐	☐	☐
Burning	☐	☐	☐
Cataracts	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Crossed Eyed	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Double Vision	☐	☐	☐
Drooping Eyelid	☐	☐	☐
Dryness	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Eye Infections	☐	☐	☐
Eye Injuries	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Glaucoma	☐	☐	☐
Itching	☐	☐	☐
Lazy Eye	☐	☐	☐
Loss of Vision	☐	☐	☐
Mucous Discharge	☐	☐	☐
Prominent Eyes	☐	☐	☐
Redness	☐	☐	☐
Retinal Disease	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Styes or Chalazion	☐	☐	☐
Tired Eyes	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
ALLERGIC (other than Hay Fever)	☐	☐	☐
IMMUNOLOGIC	☐	☐	☐

	YES	NO	?
BONES/JOINTS/MUSCLES			
Joint Pain	☐	☐	☐
Muscle Pain	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
CONSTITUTIONAL (Circle one)			
Fever, Weight Loss/Gain	☐	☐	☐
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
ENDOCRINE			
Diabetes	☐	☐	☐
Thyroid/Other Glands	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY (Circle one)			
Genitals/Kidney/Bladder	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
LYMPHATIC / HEMATOLOGIC	☐	☐	☐
Anemia/Bleeding Problems	☐	☐	☐
Cancer _____	☐	☐	☐
PSYCHIATRIC	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASCULAR			
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
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
___/____/_____	_____	_____
___/____/_____	_____	_____
___/____/_____	_____	_____
___/____/_____	_____	_____

_____
Doctor's Signature

_____
Date

JULIE GUSSENHOVEN, OD
DOCTOR OF OPTOMETRY

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 purposes of 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 claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) 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: _____

JULIE GUSSENHOVEN, OD
DOCTOR OF OPTOMETRY

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 e-mail 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.