

# OPTIC GALLERY

## Patient Medical History Questionnaire

### PERSONAL INFORMATION

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Last Eye Exam: \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_  
Spouse or parent's name \_\_\_\_\_  
If you are a student, name of school/college \_\_\_\_\_ Name of Teacher \_\_\_\_\_  
 Single  Married  Partnered  Widowed  Separated  Divorced  Minor  
E-mail: \_\_\_\_\_ Sex:  Male  Female

### INSURANCE INFORMATION:

Medical Insurance: \_\_\_\_\_ Vision Insurance: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
Employer: \_\_\_\_\_ Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

### MEDICAL HISTORY

List any known allergies to medications: \_\_\_\_\_  
List any medications you take. Please include ALL medications, including herbal and over-the-counter medications:  
\_\_\_\_\_

List all major surgeries, injuries and/or hospitalizations you have had: \_\_\_\_\_

Do YOU have or have YOU had, any of the following? If so, when you were diagnosed or treated.

Crossed eyes \_\_\_\_\_  Lazy eye \_\_\_\_\_  Eye infection \_\_\_\_\_  
 Drooping eyelids \_\_\_\_\_  Glaucoma \_\_\_\_\_  Eye injury \_\_\_\_\_  
 Cataracts \_\_\_\_\_  Retinal hole/tear \_\_\_\_\_  Macular degeneration \_\_\_\_\_

Are you pregnant or nursing?  Yes  No  
Do you currently wear glasses?  Yes  No How old are they? \_\_\_\_\_  
Do you wear contact lenses?  Yes  No How frequently do you replace them? \_\_\_\_\_  
Type of lenses:  Rigid  Soft  Other Are they comfortable?  Yes  No

### FAMILY HISTORY

Please note any family history of the following conditions:

<i><u>DISEASE/CONDITION</u></i>	<i><u>NO</u></i>	<i><u>YES</u></i>	<i><u>RELATIONSHIP TO YOU</u></i>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have visual difficulty when driving?  No  Yes If yes, explain: \_\_\_\_\_  
 Do you use tobacco products?  No  Yes If yes, type/amount/how long: \_\_\_\_\_  
 Do you use illegal drugs?  No  Yes If yes, type/amount/how long: \_\_\_\_\_  
 Do you drink alcohol?  No  Yes If yes, type/amount/how long: \_\_\_\_\_  
 Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

**Review of Systems**

Please indicate any problem you have or have had in any of the following areas:

<b><i>SYSTEM</i></b>	<b><i>NO</i></b>	<b><i>YES</i></b>	<b><i>NO</i></b>	<b><i>YES</i></b>
<b>CONSTITUTIONAL</b>				
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>		
<b>INTEGUMENTARY</b> (skin)	<input type="checkbox"/>	<input type="checkbox"/>		
<b>NEUROLOGICAL</b>				
Headaches	<input type="checkbox"/>	<input type="checkbox"/>		
Migraines	<input type="checkbox"/>	<input type="checkbox"/>		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>		
<b>EYES</b>				
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>		
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>		
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>		
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>		
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>		
Dryness	<input type="checkbox"/>	<input type="checkbox"/>		
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>		
Redness	<input type="checkbox"/>	<input type="checkbox"/>		
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>		
Itching	<input type="checkbox"/>	<input type="checkbox"/>		
Burning	<input type="checkbox"/>	<input type="checkbox"/>		
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>		
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>		
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>		
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>		
Chronic Infection of Eye	<input type="checkbox"/>	<input type="checkbox"/>		
Styes or Chalazia	<input type="checkbox"/>	<input type="checkbox"/>		
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>		
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		
<b>GENITOURINARY</b>				
Kidney/Bladder/Genitalia	<input type="checkbox"/>	<input type="checkbox"/>		
<b>EARS, NOSE, MOUTH, THROAT</b>				
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>		
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>		
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>		
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>		
Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>		
<b>RESPIRATORY</b>				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		
<b>VASCULAR/CARDIOVASCULAR</b>				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>		
<b>GASTROINTESTINAL</b>				
Stomach/Intestines	<input type="checkbox"/>	<input type="checkbox"/>		
<b>BONES/JOINTS/MUSCLES</b>				
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>		
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>		
<b>LYMPHATIC/HEMATOLOGIC</b>				
Anemia	<input type="checkbox"/>	<input type="checkbox"/>		
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>		
<b>ALLERGIC/IMMUNOLOGIC</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>ENDOCRINE</b>				
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>		
<b>PSYCHIATRIC</b>				
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>		

If "yes" to any of the above or if a condition is not listed, please explain below:

Date

Changes Noted  
(Initial Visit)

Doctor Reviewed

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# OPTIC GALLERY

## Patient Education Sheet

### Dilation of the Eyes

When were your eyes last dilated? \_\_\_\_\_

A routine dilation of the eyes is recommended at least once every 2 years. There are certain systemic and ocular conditions that require your eyes to be dilated every year.

**If you suffer from any of the following conditions you are highly recommended to have your eyes dilated today.**

- DIABETES**
- CATARACTS**
- HIGH BLOOD PRESSURE**
- HEADACHES**
- PERSONAL OR FAMILY HISTORY OF GLAUCOMA**
- FLASHES OF LIGHTS/FLOATING DOTS**

Once your eyes have been dilated, you may experience increased light sensitivity, mild blur of distance objects and the inability to focus on near objects (ie. reading may be difficult). Due to these effects, we recommend that you have someone drive you home.

If you experience severe headaches, red/painful eyes or nausea after your eyes have been dilated, please return to our office or call immediately. The doctors will be happy to answer any questions you may still have regarding this procedure.

- I wish to have my eyes dilated today.
- I do not wish to have my eyes dilated and assume the responsibility of having an eye exam without dilation.
- I wish to have a dilation scheduled for another day.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is a minor (under 18 years old), parents must sign this

# OPTIC GALLERY

## Patient Education Sheet

### Digital Retinal Photography

The D.R.P takes a digital view of the back of your eye and puts it into the format of a picture, which is saved onto a computer. This scan can be viewed immediately and examined by the Doctor while you follow along. The digital view allows the Doctor a much wider field of view than most traditional retinal exams provide of your retina. Also because the photo is saved onto a computer, it serves as documentation of the current condition of your eyes, which can aid in the tracking of any changes over the years should anything occur in the future. The Doctor strongly recommends that the patients of our offices have this procedure done to allow him/her to utilize all tools available to assess the health of the eyes, and especially if any of the following apply:

- DIABETES**
- CATARACTS**
- HIGH BLOOD PRESSURE**
- FREQUENT OR SEVERE HEADACHES**
- HIGH NEARSIGHTEDNESS**
- SYMPTOMS OF FLASHES OR FLOATERS**
- PERSONAL OR FAMILY HISTORY OF GLAUCOMA**
- OVER THE AGE OF 40**

The entire procedure takes less than 5 minutes to complete in most cases. There are no side effects to this procedure like those normally associated with dilation, such as sensitivity to light and/or blurry vision.

**The charge for this procedure is \$30.00.** If you have any further questions or concerns, the Doctor will be happy to address those with you during the exam.

**Please check one:**

- I wish to have the DRP done today
- I do not wish to have the DRP done today
- I wish to have the DRP scheduled for another day

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If patient is a minor (under 18 years old), parents must sign this form

# OPTIC GALLERY

## *SIGNATURE ON FILE*

NAME OF INSURED \_\_\_\_\_  
(LAST) (FIRST)

NAME OF PATIENT \_\_\_\_\_  
(IF OTHER THAN INSURED) (LAST) (FIRST)

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this or any subsequent office visit(s). I also understand and agree to accept responsibility for payment of any and all claims should my insurance carrier deny all or part of a claim.

I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured's health carrier must be paid for at the time of the office visit.

I hereby authorize payment directly to Dr. Lee, Dr. Potter, Dr. Young, Dr. Nguyen, Dr. Paez, Dr. Wang, or Dr. Perez for all services rendered to me by Dr. Lee, Dr. Potter, Dr. Young, Dr. Nguyen, Dr. Paez, Dr. Wang, or Dr. Perez or any of their authorized agents.

I authorize the release of all medical information to the insured's health insurance carrier that is:

- 1.) Acquired in the course of my examination or treatment
- 2.) Which may have a bearing on the benefits payable under this or any other plan that provides benefits or services

I authorize Dr. Lee, Dr. Potter, Dr. Young, Dr. Nguyen, Dr. Paez, Dr. Wang, or Dr. Perez or any of their agents to assist me in obtaining payment from my health insurance companies.

I authorize a copy of this "SIGNATURE ON FILE" form to be used in place of the original and that this copy may be used on all my insurance submissions.

\_\_\_\_\_  
INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

\_\_\_\_\_  
DATE

# OPTIC GALLERY

## Acknowledgement Notice of Privacy Practices

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Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

### ***Signing this document signifies that you have received a copy of our Notice of Privacy Practices***

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 these services, and to conduct healthcare operations involving our offices. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

### ***Record Retention Policy***

We are informing you that our office will keep your records on file for **5 years** from the date of this examination. If signing for a minor, please be aware that our office will *only keep* your child's records for **5 years** from the date of this examination.

\_\_\_\_\_  
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:

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Name