PATIENT HISTORY QUESTIONNAIRE

Important: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last name_____ First name _____ MI_____Sex_____
Address _____
City_____ State _____ Zip_____
Home phone ( )_____ Cell ( )_____ Work phone ( )_____
DOB:_____ Age_____ Occupation_____ Employer_____
Emergency contact name_____ Phone ( )_____
Date of last eye exam _____ Doctor's name _____ Dilated? Yes/No
Today's date _____ Referred by ☐ VSP ☐Phone book ☐Walk-in ☐ Friend (name)_____
Email address:_____

Medical Information

What is your general health?_____
Do you have problems with any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/lymph	Yes/No
Cardiovascular	Yes/No	Muscles/bones	Yes/No	Allergic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain_____
Other health problems_____
Diabetes Yes/No Type_____ Date of diagnosis_____

Allergies to medication? Yes/No Which?_____ Reactions?_____
Current medication(s)? Check if none ☐/ Yes(list) _____
Have you had any operations? Yes/No Kind?_____When?_____
Name of family doctor_____ Date of last visit _____

Family History

High blood pressure	Yes/No	Relation_____	Macular degeneration	Yes/No	Relation_____
Diabetes	Yes/No	Relation_____	Retinal detachment	Yes/No	Relation_____
Glaucoma	Yes/No	Relation_____	Cataracts	Yes/No	Relation_____

Personal Eye Information

Do you have any eye conditions or problem? Yes/No What kind?_____
Have you had any eye operations? Yes/No Type_____ Date_____
Have you had an eye injury? Yes/No Kind_____ Date_____
Do you have glaucoma? Yes/No Cataracts? Yes/No Dry eyes? Yes/No
Macular degeneration? Yes/No Retinal detachment? Yes/No Blurred vision? Yes/No
Do you wear glasses? Yes/No Contact lenses? Yes/No Type_____
Additional information_____

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Belmont Optique Optometric Center, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and optometric information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the following rights and privileges:

- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that [Belmont Optique Optometric Center] is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that [Belmont Optique Optometric Center] reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should [Belmont Optique Optometric Center] change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept the terms of this consent.

_____
Patient's Signature

_____
Date