MEDICAL HISTORY QUESTIONNAIRE **Today's Date** _____

Name: _____ **Birth date:** _____/_____/_____

Address: (street) _____ **Home phone:** _____

(city) _____ **Cell phone:** _____

(state) _____ (zip) _____ **Work phone:** _____

Gender: (circle one) Male Female **Marital Status:** (circle one) S M D W

Social Security Number: _____ **Full-time student:** Yes / No **Grade:** _____

Employer: _____ **Occupation:** _____

Vision Insurance: _____ **Medical Insurance:** _____

Subscriber's Name: _____ **Does your insurance require a referral?** Yes / No

Spouse: _____ **Legal Guardian:** _____

MEDICAL HISTORY:

Height: _____ **Weight:** (lbs) _____ **Last Vision Exam:** _____

Do you have any allergies? Yes / No **List any allergies, including seasonal:** _____

_____

List any medications you take, including contraceptives, over-the-counter medications, and vitamins: _____

_____

List dates and types of all major injuries, surgeries, and/or hospitalizations you have had: _____

_____

List any eye diseases or injuries you have had: _____

Do you currently wear glasses? Yes / No **If yes, how old is your present pair of lenses?** _____

Do you wear contact lenses? Yes / No **If yes, how old is your present pair of lenses?** _____

Do you need safety glasses for work? Yes / No

Have you ever had your eyes dilated? Yes / No **If yes, did you have a reaction?** Yes / No

Do you drive? Yes / No **If yes, do you have visual difficulties when driving?** Yes / No

If yes, please describe: _____

SOCIAL HISTORY: This information is strictly confidential.

Do you drink alcohol? Yes / No **If yes, how many drinks per week?** _____

Do you use tobacco products? Yes / No **If yes, type/amount/for how long?** _____

Do you use illegal drugs? Yes / No **If yes, types/amount/for how long?** _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis None of these

FAMILY HISTORY:

Please note any family history for the following conditions (ie: parents, grandparents, siblings, children - living or deceased).

Disease:	Yes / No / Unknown	Relationship to Patient:
Cancer		
Diabetes (Type I/Type II)		
High Blood Pressure		
Thyroid Disease (Hyper/Hypo)		
Cataracts		
Macular Degeneration		
Glaucoma		

REVIEW OF SYSTEMS: *Have you ever had any problems in the following areas?*

	No	Yes	Not sure
NEUROLOGICAL:			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
VISION:			
Loss of vision	☐	☐	☐
Blurred distance vision	☐	☐	☐
Blurred near vision	☐	☐	☐
Distorted vision/halos	☐	☐	☐
Loss of side vision	☐	☐	☐
Double vision	☐	☐	☐
Glare/light sensitivity	☐	☐	☐
Chronic infections	☐	☐	☐
Stye or chalazion	☐	☐	☐
Flashes/floaters	☐	☐	☐
DRY EYE:			
Dryness	☐	☐	☐
Mucous discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or gritty feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign body sensation	☐	☐	☐
Excessive tearing	☐	☐	☐
Eye pain or soreness	☐	☐	☐
Tired eyes	☐	☐	☐

OTHER:_____

	No	Yes	Not sure
ENDOCRINE:			
Thyroid/other glands	☐	☐	☐
EARS, NOSE, MOUTH, THROAT:			
Allergies, hay fever	☐	☐	☐
Sinus congestion	☐	☐	☐
Runny nose	☐	☐	☐
Post-nasal drip	☐	☐	☐
Chronic cough	☐	☐	☐
Dry mouth/throat	☐	☐	☐
RESPIRATORY:			
Asthma	☐	☐	☐
Chronic bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR/CARDIOVASCULAR:			
Diabetes (Type I or II)	☐	☐	☐
Heart pain	☐	☐	☐
High blood pressure	☐	☐	☐
Vascular disease	☐	☐	☐
BONES/JOINTS/MUSCLES:			
Rheumatoid arthritis	☐	☐	☐
Muscle pain	☐	☐	☐
Joint pain	☐	☐	☐
LYMPHATIC/HEMATOLOGIC:			
Anemia	☐	☐	☐
Bleeding problems	☐	☐	☐

Emily Eye Care, LLC
Lily Yeh, O.D. and Austin White, O.D.
139 Hazard Avenue, Building 1, Unit 1, Enfield, CT 06082
Phone: (860) 749-1233 Fax: (860) 749-4613

Name(s):_____ **Date:**_____

Please indicate which method you prefer to be contacted by:

Cell:_____ **May we call?** Yes / No **May we text?** Yes / No

Home:_____ **May we call?** Yes / No

Work:_____ **Ext.**_____ **May we call?** Yes / No

Email Address:_____

Which method do you prefer to be contacted by first? (circle one) Cell / Home / Work / Email

***We only use your contact information to notify you when your glasses and/or contacts are in, if you are due for an appointment, and to confirm any upcoming appointments. We do NOT sell your information.

Emergency Contact Information:

In case of emergency, please list someone we can contact:

Name:_____ **Relationship:**_____

Contact Information:_____ (circle one) Home / Cell

Please provide us with your primary care physician's information:

Primary Care Physician:_____ **Phone:**_____

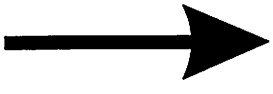
Practice Name:_____ **Fax:**_____

If there are any specialists you see who should receive a copy of any reports written by the doctor, please give us their contact information.

Specialist/Practice Name:_____ **Phone:**_____

Specialty:_____ **Fax:**_____

What pharmacy do you use?_____ **Location:**_____



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ACKNOWLEDGEMENT OF RECEIPT OF OUR *NOTICE OF PRIVACY PRACTICE*

Name(s):_____ **Phone Number:**_____

Address:_____

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 healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from the office of Emily Eye Care.

_____ _____

Signature **Date**

If signing this 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** **Source of Authority**

Insurance Coverage & Billing Notice:

I understand that I am responsible for providing Emily Eye Care with my current insurance information and that I am responsible for any remaining balance for services or materials not covered by my insurance. If any medical testing is done by the doctor, it will be billed to my medical insurance and may be applied to my deductible for which I will be responsible.

_____ _____

Signature **Date**

Experience the convenience of the OPTOS CALIFORNIA - now at Emily Eye Care!

The new Optos California provides a 200 degree view of your retina in a high resolution, high contrast digital image - the Optomap! This comprehensive, one image view of up to 82% of the retina gives the doctors the opportunity to identify and follow peripheral retinal pathology much more easily. Unlike dilation, there is no downtime waiting for the results. Each image takes less than a second to capture! **THE OPTOMAP DOES NOT REQUIRE RADIATION TO CAPTURE THE IMAGE!**

To provide the highest level of care, Dr. Yeh and her associates *strongly recommend* that all of our patients have this procedure performed *annually*. It is especially important for patients who have one or more of the following:

- Floaters, spots, or flashes of light in vision
- Headaches or ocular migraines
- Vision not correctable to 20/20
- Nearsightedness
- Recent substantial changes in vision
- Family/personal history of diabetes
- Family/personal history of high blood pressure or high cholesterol
- Family/personal history of glaucoma
- Family/personal history of macular degeneration or other retina disorders
- Never had the procedure before

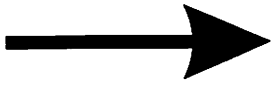
If pathology or unusual anatomy is documented with this testing, the images can be billed to your medical insurance as part of your treatment plan. These charges may be applied to your deductible if it has not yet been met. There may also be separate copay or coinsurance charges applied. If the scans do not detect any abnormal condition(s), the photos will not be covered by insurance and you will be responsible for a fee of $40.

Please check the appropriate line:

- ❑ I DO want the Optomap performed.
- ❑ I DO NOT want the Optomap performed and prefer DILATION.
- ❑ I DO NOT want to have the Optomap or dilation performed on me this year.
- ❑ I would like to talk to the doctor to get more information first.

Patient's Name:_____

Signature:_____ **Date:**_____



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Annual Contact Lens Notification:

Today's successful contact lens progress evaluation is an essential element of your continued lens' safety and comfort. Always pay very close attention to any out-of-the-ordinary symptoms or eye irritation. Many factors may interfere with optimum contact lens performance. These can include ocular inflammation or infection, changes in prescription, dry eyes, seasonal allergies, improper lens' discard timetable, overwearing of contacts, irritation from smoking, environmental influences, cosmetics, and lens care product compatibility.

Contact lenses require a medical prescription and, at a minimum according to federal law, a yearly progress evaluation to renew their ocular suitability and vision accuracy. All contact lens wearers need to annually update their contact lens prescription which is not the same as an eyeglass prescription because it includes a base curve, diameter, and brand name. This evaluation is in addition to a routine eye exam. There is a contact lens re-evaluation fee, the amount for which varies according to the type of contact lens you wear.

By signing this form, I understand that an annual contact lens re-evaluation is required to purchase contact lenses. It is not included in my routine eye exam and may not be covered by my insurance.

Patient's Name:_____ **Date:**_____

Signature:_____ **Relationship to Patient:**_____