

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes	Not sure
VISION:			
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred distance vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred near vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision/halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stye or chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/floaters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes	Not sure
DRY EYE:			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER: _____

	No	Yes	Not sure
ENDOCRINE:			
Thyroid/other glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes	Not sure
EARS, NOSE, MOUTH, THROAT:			
Allergies, hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth/throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes	Not sure
RESPIRATORY:			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes	Not sure
VASCULAR/CARDIOVASCULAR:			
Diabetes (Type I or II)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes	Not sure
BONES/JOINTS/MUSCLES:			
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes	Not sure
LYMPHATIC/HEMATOLOGIC:			
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Please update any information that may have changed. Check here if nothing has:

Name(s): _____

Street/PO Box: _____

City/Town: _____ **State:** _____ **Zip Code:** _____

Date(s) of Birth: _____ **Social Security Number:** _____

Please update your contact information and indicate which method you prefer:

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: _____

***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.

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
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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
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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
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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!

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:** _____

Emily Eye Care introduces our new CONTACT LENS WEBSTORE!

- Order your contacts from the comfort of your home at any time of day & have them shipped to your door for free!*
- Your insurance plan's contact lens benefit can be applied to your order.
- Inquire at the front desk for additional discounts & rebate information.
- Our prices are comparable to other online contact lens stores!
- You can sign up in our office or on our website, www.drilyeh.com.

*Free shipping on orders over \$150.

