ADVANCED VISION CARE

PATIENT HISTORY QUESTIONNAIRE

25910 Iris Ave., Suite #2A, Moreno Valley, CA 92551 **Tel: (951) 243-3337** **Fax: (951) 243-6868**

Please check one: ☐ New Patient ☐ Returning Patient Appt. Date: _____Day _____ Appt. Time: _____

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

Last name _____ First name _____ MI _____

Address _____ City _____ State _____ Zip _____

Home phone (____) _____ Cell phone (____) _____ Work phone (____) _____

Name of Vision Insurance _____ Insured's ID # / SS # _____Name of Medical Insurance_____

Date of last eye exam _____Pupils Dilated? Yes / No Reason for visit: ☐ Glasses ☐ Contact Lens ☐ Both

DOB _____ Occupation _____ Employer _____

Emergency Contact Name _____ Phone number (____) _____

Today's date _____ Any secondary vision insurance? Y/N Flex card? Y/N Referred by _____

Medical Information

How is your general health? _____

Do you have problems with any of these systems? (**Please circle yes or no**) Cancer/kind?_____ Yes / No

Gastrointestinal	Yes / No	Neurological	Yes / No	Endocrine(diabetes,thyroid)	Yes / No
Ears/Nose/Throat	Yes / No	Urinary	Yes / No	Blood/lymph	Yes / No
Cardiovascular	Yes / No	Muscles/bones	Yes / No	Allergic/immunologic	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 _____

Diabetes Yes / No Type _____ Date of diagnosis _____

Allergies to medication? Yes / No Which? _____ Reactions? _____

Other health problems _____

Current medication(s) _____ Check if none ☐

Have you ever had any operations? Yes / No What kind? _____ When? _____

Name of family doctor _____ Date of last visit _____

Are you pregnant? Yes / No Are you nursing? Yes / No Do you smoke Yes/No Do you drink? Yes/ No

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 problems? Yes / No What kind? _____

Have you had any eye operations? Yes / No Type _____ Date _____

Have you had an eye injury? Yes / No What 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	Uncomfortable glasses?	Yes / No	Corneal abrasion?	Yes / No
Eye infection?	Yes / No	Iritis/uveitis?	Yes / No	Lazy eye?	Yes / No
Glare? (daytime/nighttime)	Yes / No	Headaches?	Yes / No	Itchiness?	Yes / No
Burning?	Yes / No	Double vision?	Yes / No	Grittiness?	Yes / No
Tearing?	Yes / No	Trouble seeing at night?	Yes / No	Flash of light?	Yes / No
Sunlight sensitivity?	Yes / No	Crossed eye/eye turn?	Yes / No	Floater/spots?	Yes / No

*__Turn page over to BACK (answer or/& sign only if applicable)__

If You Are A Contact Lens Wearer: **or N/A**

Which solution do you use? Renu / Optifree / Complete /Other _____

Average amount of time wearing (hours/day)? 8 / 10 / 12 /14 / 16 / Other _____

Do you rub your contacts when you clean them? Yes / No

How often do you dispose of your contacts? 2 weeks /1 month / 3 months / Yearly / Other _____

Do wear contacts while sleeping? Yes / No If yes, how many days a week? _____

If you wear contact lenses, are you satisfied with the vision and comfort? Yes / No

What type and brand of contacts do you wear? _____

What power and base curve do you wear? _____

*****(Read and Sign only if you are a New Patient)*****

HIPAA Privacy
Acknowledgement of Receipt of Privacy Notice

By signing this acknowledgement of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge that I have been provided with a copy of the Notice of Privacy for review and to keep for my records on the date signed below.

I understand that the Location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or types of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services (including referral to another provider/specialist as needed for my treatment) and products, process my benefit claims and communicate with me regarding vision care services provided by the Location (for example, mailings of exam reminders or information about vision services/products provided by the Location).

I can be assured that this Location does not sell my personal health information of any kind to the third party for such party's own use. I authorize the Location to submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from this Location.

_____ _____

Patient Signature or Patient's Legal Representative **Date**