ADVANCED VISION CARE
OPTOMETRY

14140 Meridian Parkway, Suite 101 Riverside, CA 92518
Phone 951-243-3337, Fax 951-243-6868, Email reception@avceyecare.net

PATIENT QUESTIONNAIRE FORM

Please circle one: New Patient/ Returning Patient Appt. Date: _____Day _____ Appt. Time: _____

Last name _____ First name _____ MI _____

Address _____ City _____ State _____ Zip _____

Cell phone (____) _____Email_____Occupation_____

DOB _____ Employer _____Medical Ins_____

Name of Vision Insurance _____Primary's ID/Social _____

Any secondary vision insurance?_____Referred by_____

Emergency Contact Name _____Phone number (____) _____

Date of last eye exam _____Were Pupils Dilated? Yes / No Were Retina Photos done? Yes/ No

Medical Information

Do you have problems with any of these systems? (**Please circle yes or no**)

- Diabetes Yes / No Type _____ Date of diagnosis_____
- High Blood Pressure Yes / No
- Thyroid Yes / No
- High Cholesterol Yes / No
- Cancer/Type?_____ Yes/ No
- Autoimmune Dz/Type?_____Yes/ No

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

Current medication(s) _____

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 Are you trying to get pregnant? Yes/ No

Do you smoke? Yes/ No Do you drink alcohol? Yes/ No

Family History

Macular degeneration Yes / No Relation _____ Retinal detachment Yes / No Relation _____

Glaucoma Yes / No Relation _____ Other _____

Personal Eye Information

Are you interested in (circle): Eyeglasses/ Sunglasses/ Contact Lenses/ Lasik Info/ Safety Rx/ Sport goggles rx/
Other: _____
Are you having any problems with your vision that made you come in? _____
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
Other eye disorders?	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	Flashes of light?	Yes / No
Sunlight sensitivity?	Yes / No	Crossed eye/eye turn?	Yes / No	Floaters/spots?	Yes / No

Additional information _____

If You Are A Contact Lens Wearer

What brand? _____Power? R:_____L:_____BC_____
Which solution do you use? Optifree PureMois t/ BioTrue / Revitalens/ ClearCare / Generic / _____
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? 1 Day/ 2 weeks / 1 month / 3 mos / 6 mos/ Yearly / _____
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

Retina Imaging/ Optomap

To assess the internal eye health, we either dilate your eyes or perform an Optomap image. The Optomap image gives us the information we need to give you a high level exam while maintaining a safe distance. This scan will be used in the future to compare and monitor any changes to your eye health. There is a $39 fee/copay for the procedure.

- ☐ **Yes, I agree to Optomap**
- ☐ **I have questions for the doctor**

HIPAA Privacy Notice/ 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. Paperless copy of the notice is available at our website at www.avceyecare.net.
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**