Medical History Questionnaire

Lafayette Optometric Group

Today's Date: _____ / _____ / _____

Name: _____ Birth Date: _____ / _____ / _____

Guardian (If applicable): _____ Relationship: _____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? ☐ N ☐ Y If yes, any visual concerns?: _____

Do you use tobacco products? ☐ N ☐ Y If yes, type/amount/duration: _____

Do you drink alcohol? ☐ N ☐ Y If yes, type/amount/duration: _____

Do you use drugs recreationally? ☐ N ☐ Y If yes, type/amount/duration: _____

Have you ever been exposed to or infection with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Medical History

Last Eye Exam: _____ / _____ / _____ Last Medical Exam: _____ / _____ / _____

Do you have any allergies to medications? ☐ N ☐ Y If yes, please explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications, and home remedies):

_____

_____

_____

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

_____

Are you pregnant and/or nursing? ☐ N ☐ Y

EYE | Do you have any of the following: ☐ no to all

Blurry Vision	☐ N ☐ Y	Tired eyes	☐ N ☐ Y	Dryness	☐ N ☐ Y	Redness	☐ N ☐ Y
Irritation	☐ N ☐ Y	Itchiness	☐ N ☐ Y	Pain	☐ N ☐ Y	Tearing	☐ N ☐ Y
Discharge	☐ N ☐ Y	Light sensitivity	☐ N ☐ Y	Double vision	☐ N ☐ Y	Flashes/Floaters	☐ N ☐ Y

Other: _____

EYE | Have you ever had/been diagnosed with (F = Family; please specify relation below): ☐ no to all

Amblyopia	☐ N ☐ Y ☐ F	Cataracts	☐ N ☐ Y ☐ F	Eye infection	☐ N ☐ Y	Eye injury	☐ N ☐ Y
Eye Surgery	☐ N ☐ Y ☐ F	Glaucoma	☐ N ☐ Y ☐ F	Retinal disease	☐ N ☐ Y ☐ F	Strabismus	☐ N ☐ Y ☐ F

Other: _____

SYSTEMIC | Do you have any of the following (F = Family; please specify relation below): ☐ no to all

Allergic/Immunologic: ☐ N ☐ Y

Bones/Joints/Muscles: ☐ N ☐ Y

Cardiovascular/Vascular:

- Cholesterol: ☐ N ☐ Y ☐ F
- Diabetes: ☐ N ☐ Y ☐ F
- Hypertension: ☐ N ☐ Y ☐ F
- Other: ☐ N ☐ Y ☐ F

Ear/Nose/Throat: ☐ N ☐ Y

Endocrine (glands): ☐ N ☐ Y

Gastrointestinal: ☐ N ☐ Y

Genitourinary: ☐ N ☐ Y

Hematologic/Lymphatic: ☐ N ☐ Y

Integumentary (skin): ☐ N ☐ Y

Neurological: ☐ N ☐ Y

Psychiatric: ☐ N ☐ Y

Respiratory: ☐ N ☐ Y

Other: ☐ N ☐ Y

If you answered yes to any of the above conditions, please specify/explain further: _____

_____

_____

_____

☐ Reviewed by doctor: _____ Date: _____

Acknowledgement of Receipt

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 Lafayette Optometric Group.

_____ _____

Signature Date

If signing as a personal representative, describe relationship to the patient and the source of authority to sign this form:

_____

LAFAYETTE OPTOMETRIC GROUP

DR. NICHOLAS C. CHRISTIE DR. FRANK G. ZHENG DR. MELISSA S. NGO
DR. LILLIAN I. WANG DR. ALLISON M. CHOI

WELCOME TO OUR OFFICE

Today's Date: __/__/__ **Please Print**

Patient Legal Name: _____
First M.I. Last

Preferred Name: _____ Gender: ☐ M ☐ F ☐ Other: _____
Include pronouns

Birthdate: __/__/__ Soc Sec No: ___-__-___

Address: _____
Street

_____
City State Zip

Home Phone: (__) _____ Work Phone: (__) _____

Cell Phone: (__) _____ Email Address: _____

Occupation: _____ Company Name: _____

If Student, Grade: _____ School: _____

Parent or Guardian: _____ Relationship: _____

Spouse: _____

General Physician: _____ Location: _____
City State

When Was Your Last Eye Exam? _____

Who Was Your Eye Doctor? _____ Location: _____
City State

Yes No
☐ ☐ Have You Ever Worn Glasses?
☐ ☐ Do You Wear Glasses Now?
☐ ☐ Have you Ever Worn Contacts?
☐ ☐ Do You Wear Contacts Now?

How did you hear of our office?
☐ Referral from a ☐friend or ☐relative
Name : _____
☐ Vision Service Plan List
☐ Yelp

Who Is Responsible For Payment Or Insurance Co-Payment Of This Account?

Name: _____

Address: _____

Do You Have Vision Insurance? ☐ Yes ☐ No Company? _____

PAYMENTS FOR MATERIALS AND SERVICES ARE TO BE MADE AT THE TIME THEY ARE RENDERED. IF SPECIAL ARRANGEMENTS ARE NECESSARY, PLEASE DISCUSS YOUR NEEDS WITH US. THANK YOU.