Medical History Questionnaire

Name: _____ Today's Date: _____

Address: _____ Phone: _____

_____ Work Phone: _____

Guardian (If Applicable): _____ Occupation: _____

Email: _____ Preferred Language: _____

Birth Date: _____ Social Security #: _____ Race/Ethnicity: _____

Gender: _____ Date of Last Eye Exam: _____ Date of Last Medical Exam: _____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Medical History

Do you have any allergies to medications? ❒ no ❒ yes If yes, 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: _____

_____

Check any of the following that you have had: ❒ crossed eyes ❒ lazy eye ❒ drooping eyelid ❒ prominent eyes

❒ Glaucoma ❒ retinal disease ❒ cataracts ❒ eye infections ❒ eye injury

Are you pregnant or nursing? ❒ no ❒ yes

Do you wear glasses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ❒ no ❒ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ yes ❒ no

Family History: note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions.

Disease/Condition	No	Yes	?	Relationship To You
Blindness	❒	❒	❒	
Cataract	❒	❒	❒	
Crossed Eyes	❒	❒	❒	
Glaucoma	❒	❒	❒	
Macular Degeneration	❒	❒	❒	
Retinal Detachment or Disease	❒	❒	❒	
Arthritis	❒	❒	❒	

Disease/Condition	No	Yes	?	Relationship To You
Cancer	❒	❒	❒	
Diabetes	❒	❒	❒	
Heart Disease	❒	❒	❒	
High Blood Pressure	❒	❒	❒	
Kidney Disease	❒	❒	❒	
Lupus	❒	❒	❒	
Thyroid Disease	❒	❒	❒	
Other: _____				

✳ ***Please Turn This Form Over & Complete Side Two*** ✳

Social History: *This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.*

❒ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❒ no ❒ yes If yes, do you have visual difficulty when driving? ❒ no ❒ yes If yes, please describe:

_____

Do you use tobacco products? ❒ no ❒ yes If yes, type/amount/how long: _____

Do you drink alcohol? ❒ no ❒ yes If yes, type/amount/how long: _____

Do you use illegal drugs? ❒ no ❒ yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ❒ Gonorrhea ❒ Hepatitis ❒ HIV ❒ Syphilis

Review of Systems: Do you currently, or have you ever had any problems in the following areas?

System	NO	YES	?
Constitutional			
Fever, Weight Loss/Gain	❒	❒	❒
Integumentary (Skin)	❒	❒	❒
Neurological			
Headaches	❒	❒	❒
Migraines	❒	❒	❒
Seizures	❒	❒	❒
Eyes			
Loss of Vision	❒	❒	❒
Blurred Vision	❒	❒	❒
Distorted Vision/Halos	❒	❒	❒
Loss of Side Vision	❒	❒	❒
Double Vision	❒	❒	❒
Dryness	❒	❒	❒
Mucous Discharge	❒	❒	❒
Redness	❒	❒	❒
Sandy or Gritty Feeling	❒	❒	❒
Itching	❒	❒	❒
Burning	❒	❒	❒
Foreign Body Sensation	❒	❒	❒
Excess Tearing/Watering	❒	❒	❒
Glare/Light Sensitivity	❒	❒	❒
Eye Pain or Soreness	❒	❒	❒
Chronic Infection, Eye or Lid	❒	❒	❒
Sties or Chalazion	❒	❒	❒
Flashes/Floaters in Vision	❒	❒	❒
Tired Eyes	❒	❒	❒
Endocrine			
Thyroid/Other Glands	❒	❒	❒

System	NO	YES	?
Ears, Nose, Mouth, Throat			
Allergies/Hay Fever	❒	❒	❒
Sinus Congestion	❒	❒	❒
Runny Nose	❒	❒	❒
Post-Nasal Drip	❒	❒	❒
Chronic Cough	❒	❒	❒
Dry Throat/Mouth	❒	❒	❒
Respiratory			
Asthma	❒	❒	❒
Chronic Bronchitis	❒	❒	❒
Emphysema	❒	❒	❒
Vascular / Cardiovascular			
Diabetes	❒	❒	❒
Heart Pain	❒	❒	❒
High Blood Pressure	❒	❒	❒
Vascular Disease	❒	❒	❒
Gastrointestinal			
Diarrhea	❒	❒	❒
Constipation	❒	❒	❒
Genitourinary			
Genitals/Kidney/Bladder	❒	❒	❒
Bones / Joints / Muscles			
Rheumatoid Arthritis	❒	❒	❒
Muscle Pain	❒	❒	❒
Joint Pain	❒	❒	❒
Lymphatic / Hematologic			
Anemia	❒	❒	❒
Bleeding Problems	❒	❒	❒
Allergic / Immunologic	❒	❒	❒
Psychiatric	❒	❒	❒

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

_____

_____ _____

Doctor's Signature

Notice of Privacy Practices

Dr. Dorothy Okamoto
3714 MacArthur Blvd. Oakland, CA 94619
Phone: (510) 530-2330
Fax: (510) 530-4947

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule

We respect our legal obligation to keep health information that identifies you private. The law obligates us to give you notice of our privacy practices.

Generally, we can only use your health information in our office or disclose it outside of our office, without your written permission, for purposes of treatment, payment or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

Examples of how we use information for **treatment** purposes:

- When we set up an appointment for you.
- When our technician or doctor tests your eyes.
- When the doctor prescribes glasses or contact lenses.
- When the doctor prescribes medication.
- When our staff helps you select and order glasses or contact lenses.
- When we show you low vision aids.

We may disclose your health information outside of our office for **treatment** purposes, for example:

- If we refer you to another doctor or clinic for eye care or low vision aids or services.
- If we send a prescription for glasses or contacts to another professional to be filled.
- When we provide a prescription for medication to a pharmacist.
- When we phone to let you know that your glasses or contact lenses are ready to be picked up.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for **payment** purposes. Some examples are:

- When our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services.
- When we prepare bills to send to you or your health or vision care plan.
- When we process payment by credit card and when we try to collect unpaid amounts due.
- When bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for **healthcare operations** in a number of ways. Health care operations means those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Appointment Reminders

We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you.

Uses & Disclosures without an Authorization

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never happen at our office at all. Such uses or disclosures are:

- A state or federal law that mandates certain health information be reported for a specific purpose.
- Public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs or medical devices.
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the licensing of doctors, audits by Medicare or Medicaid, or investigation of possible violations of healthcare laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.

- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations.
- Uses or disclosures for health related research.
- Uses and disclosures to prevent a serious threat to health or safety.
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service.
- Disclosures relating to workers' compensation programs.
- Disclosures to business associates who perform healthcare operations for us and who agree to keep your health information private.

Other Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written **authorization form**. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

Your Rights Regarding Your Health Information

The law gives you many rights regarding your health information.

- You can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or healthcare operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to **Dr. Dorothy Okamoto** at the address, fax or e-mail shown at the beginning of this notice.
- You can ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to **Dr. Dorothy Okamoto** at the address, fax or e-mail shown at the beginning of this notice.
- You can ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we sent you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to **Dr. Dorothy Okamoto** at the address, fax or e-mail shown at the beginning of this notice.
- You can ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to **Dr. Dorothy Okamoto** at the address, fax or e-mail shown at the beginning of this notice.
- You can get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by you, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to **Dr. Dorothy Okamoto** at the address, fax or e-mail shown at the beginning of this notice.

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to **Dr. Dorothy Okamoto** at the address, fax or e-mail shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

For More Information

If you want more information about our privacy practices, call or visit **Dr. Dorothy Okamoto** at the address or phone number shown at the beginning of this notice.

Acknowledge of Receipt of Notice of Privacy Practices

Laurel Optometry
Dr. Dorothy Okamoto
Phone: (510) 530-2330
Fax: (510) 530-4947

3714 MacArthur Blvd.
Oakland, CA 94619

Patient Name: _____
Patient Phone Number: _____
Patient Address: _____

Signing this document signifies that you have received a copy of our *Notice of Privacy Practices*.

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 health care 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 Laurel Optometry.

_____ _____
Signature Date

If signing 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: _____