RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your right under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information (PHI) about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PATIENT'S DESIGNATION OF PREFERRED MANNER OF CONTACT

I wish to be contacted in the following manner (check all that apply):

Oral communication:

Home telephone ______________________

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

Work telephone ________________

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

Other ____

Written communication:

☐ OK to mail to my home address

☐ OK to fax to this number ____________

☐ I permit Perrysburg Eye Center to discuss my PHI with, and to disclose my PHI to the following individuals:

- ☐ Spouse ____
- ☐ Adult child(ren) ______________________________________
- ☐ Other ____

_____________________________ Patient's Name

_____________________________ Signature

Relationship to patient: ___________

Date: ______________________________

To Be Completed by Provider Personnel

______ Written acknowledgment was not obtained. Efforts to obtain the acknowledgment and reason not obtained are described below:

____

Completed by: _______________ Print Name

_______________________ Signature

_________________ Date

Form 115
12-08

Medical History Questionnaire

Name ______________________ Today's Date ______________________
Birth Date ______________ Date of last eye exam __________ Social Security #______________________

Name of physician referring you ______________________ Physician's phone# ______________________
Referring Physician's address ______________________

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "yes", provide information.

Eyes

	YES	NO
Loss of vision	[ ]	[ ]
Blurred or distorted vision	[ ]	[ ]
Loss of side vision	[ ]	[ ]
Double vision	[ ]	[ ]
Fluctuating vision	[ ]	[ ]
Dryness	[ ]	[ ]
Mucous discharge	[ ]	[ ]
Redness	[ ]	[ ]
Sandy or gritty feeling	[ ]	[ ]
Itching or burning	[ ]	[ ]
Excess tearing/watering	[ ]	[ ]
Occasional tearing	[ ]	[ ]
Glare/Light sensitivity	[ ]	[ ]
Eye pain or soreness	[ ]	[ ]
Chronic infection of eye or lid	[ ]	[ ]

EXPLANATION OF PROBLEM ______________________

Ears, nose, mouth, throat

	YES	NO
Sinus congestion	[ ]	[ ]
Runny nose	[ ]	[ ]
Post-nasal drip	[ ]	[ ]
Chronic cough	[ ]	[ ]
Dry throat/mouth	[ ]	[ ]

EXPLANATION OF PROBLEM ______________________

Respiratory (lungs/breathing)

	YES	NO
Emphysema	[ ]	[ ]
Other	[ ]	[ ]

EXPLANATION OF PROBLEM ______________________

Allergic/Immunologic

	YES	NO
Drug allergies	[ ]	[ ]
Seasonal allergies	[ ]	[ ]
Contact allergies	[ ]	[ ]
Food allergies	[ ]	[ ]

EXPLANATION OF PROBLEM ______________________

Cardiovascular

	YES	NO
Heart disease	[ ]	[ ]
Stroke	[ ]	[ ]
Hypertension	[ ]	[ ]
Other	[ ]	[ ]

EXPLANATION OF PROBLEM ______________________

Gastrointestinal

	YES	NO
Stomach	[ ]	[ ]
Intestines	[ ]	[ ]

EXPLANATION OF PROBLEM ______________________

Genitourinary

	YES	NO
Genitals	[ ]	[ ]
Kidney/Bladder	[ ]	[ ]

EXPLANATION OF PROBLEM ______________________

Musculoskeletal

	YES	NO
Arthritis	[ ]	[ ]
Muscle/joint pain	[ ]	[ ]

EXPLANATION OF PROBLEM ______________________

Integumentary

	YES	NO
Skin/Breast	[ ]	[ ]
Other	[ ]	[ ]

EXPLANATION OF PROBLEM ______________________

	YES	NO	
Neurological/Psychiatric	[ ]	[ ]	EXPLANATION OF PROBLEM ______

Endocrine	YES	NO	
Thyroid	[ ]	[ ]	EXPLANATION OF PROBLEM ______
Diabetes	[ ]	[ ]	______

Hematologic/Lymphatic	YES	NO	
Blood	[ ]	[ ]	EXPLANATION OF PROBLEM ______
Lymph nodes	[ ]	[ ]	______

Constitutional Symptoms			
Fever	[ ]	[ ]	EXPLANATION OF PROBLEM ______
Weight loss	[ ]	[ ]	______

PAST HISTORY

List any medications you take: ______

List all major illnesses and injuries: ______

List any surgeries you have had: ______

Have you had crossed eyes, lazy eye, drooping eyelid, prominent eyes? ______

Do you have any allergies to any medications? If yes, list medications: ______

Are you allergic to latex? ______

FAMILY HISTORY

DISEASE	YES	NO	RELATIONSHIP TO PATIENT	DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Amblyopia	[ ]	[ ]	______	Heart attacks	[ ]	[ ]	______
Blindness	[ ]	[ ]	______	High blood pressure	[ ]	[ ]	______
Cataract	[ ]	[ ]	______	Kidney disease	[ ]	[ ]	______
Crossed eyes	[ ]	[ ]	______	Lupus	[ ]	[ ]	______
Glaucoma	[ ]	[ ]	______	Sjogren's Syndrome	[ ]	[ ]	______
Macular degeneration	[ ]	[ ]	______	Stroke	[ ]	[ ]	______
Retinal detachment	[ ]	[ ]	______	Thyroid disease	[ ]	[ ]	______
Arthritis	[ ]	[ ]	______	Tuberculosis	[ ]	[ ]	______
Cancer	[ ]	[ ]	______	Other	[ ]	[ ]	______
Diabetes	[ ]	[ ]	______				

SOCIAL HISTORY

Current occupation: ______

Do you drive? [ ] Yes [ ] No

Do you have problems with night vision? [ ] Yes [ ] No

Do you currently wear glasses? [ ] Yes [ ] No

Do you drink alchohol [ ] Yes [ ] No

Do you smoke? [ ] Yes [ ] No

Have you ever had a blood transfusion? [ ] Yes [ ] No

Do you have visual difficulty when driving? [ ] Yes [ ] No

Have you ever tried to wear contacts? [ ] Yes [ ] No

If "Yes", how long have you had the current pair? ______

If "Yes", how many glasses per day? ______

If "Yes", how many packs per day? ______

Have you ever been in intimate contact with a person who had a sexually transmitted disease? [ ] Yes [ ] No

FOR OFFICE USE ONLY:

History reviewed [ ] No changes [ ] Additions as noted above [ ]

Physician's signature: ______ Date: ______