FOSTER CITY EYE CARE - OPTOMETRIC CENTER
PATIENT HISTORY QUESTIONNAIRE

Last name First name Mr.❑ Mrs.❑ Miss.❑ Ms.❑
Address
Telephone (W) (H) (Cell)
SSN - - Date of Birth Age
Occupation Computer Hours Per Day
Employer **E-MAIL:**
Emergency contact/Telephone no.
Date of last eye exam Dilated? Today's Date
Hobbies or Sports
Primary reason for today's exam

MEDICAL INFORMATION

What is your general health:
Do you have any problems with any of these systems? (please circle all

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ear/Nose/Throat	Y/N	Genitourinary	Y/N	Mental	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Endocrine (glands)	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Blood/lymph	Y/N
				Allergic/immunologic	Y/N
				Pregnant or nursing	Y/N

Please explain

Please answer all

Diabetes Y/N Type Date of diagnosis
Allergies Y/N Allergic to what? What happens?
Medication allergy Y/N What happens? Headaches Y/N
Other health problems HIV/AIDS Y/N
Current medication(s)
Have you had any operations? Y/N Kind? When?
Do you use cigarettes/tobacco? Alcohol? Other substance(s)?
Name of family doctor Date of last visit
Date of last tetanus shot

FAMILY HISTORY

High blood pressure Y/N Relation Macular degeneration Y/N Relation
Diabetes Y/N Relation Retinal detachment Y/N Relation
Glaucoma Y/N Relation Cataracts Y/N Relation
Other eye condition(s) Y/N What kind? Relation

PERSONAL EYE INFORMATION

Have you had an eye operation? Y/N Type Date
Have you had an eye injury? Y/N Kind Date
Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N
Other eye problems? Y/N What kind?
Do you wear glasses? Y/N Contact lenses? Y/N Type
Additional information Are you interested in new contact lenses? Y/N
Whom may we thank for referring you?

X

Lens Selection Survey

For us to assist you in making informed choices about the best lens design for your new eyewear, please provide the following information to the best of your ability.
Please circle all of the visual activities you participate in:

Theater/Opera	Cook	Sew	Read
Bicycle	Crochet/Knit	Ski	Surf
Boat	Draw/Paint	Snorkel/Dive	Target Shoot
Bowling	Fishing	Swimming	Television
Modeling	Gardening	Musical Instrument	Tennis
Card Games	Golf	Operate Machinery	Type
Ceramics	Home Repair	Photography	Water Ski
Collect Stamps/Coins	Hunt	Airplanes	Writing
Other(specify)			

Acknowledgement of Receipt of Notice of Privacy Practices

Foster City Eye Care Optometric Center
939 Edgewater Blvd., Suite C
Foster City, CA 94404
(650) 573-6245

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 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

Foster City Eye Care Optometric Center

______________________________ ______________
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: ____