Eye Level Inc.

Patient History Questionnaire

Completion required at each patient appointment

Please complete all questions.

Last Name: ______________________ First Name: ______________________ MI: ____

Address: ____

City: ____________________ State: ________ Zip code: ____________ - ____________

H. Phone: ______________ W. Phone: ______________ Ext: __________ Cell/Pager: ______________

Email: ____________________ SSN: ______ - _____ - _________ Birth Date: _____ / ______/ _________

Please indicate marital status S _____M _____ D _____ W _____

Employer:______________________ Occupation :______________________

Emergency Contact:______________ Relationship: ______________ Phone: ______________

Date of Last Eye Exam:______________ Dilated? Y / N

Today's Date: _____/______/________ (Format: mm/dd/yyyy)

Medical Information

Certain medical conditions are more prominent in certain ethnicities. Glaucoma is more prevalent in African Americans, Asians, and Hispanics. For this reason only, we ask you to ***circle your ethnic background*** .

Asian African American Caucasian Chinese Hispanic Combined

What is your general health? ____________________________________

Do you have problems in any of the following systems? ***(Please circle Y or N)***

(1) Gastrointestinal	Y / N	(5) Nervous	Y / N	(9) Eyes	Y / N
(2) Ear / Nose/ Throat	Y / N	(6) Genitourinary	Y / N	(10) Mental	Y / N
(3) Cardiovascular	Y / N	(7) Musculoskeletal	Y / N	(11) Endocrine	Y / N
(4) Respiratory	Y / N	(8) Integumentary (skin)	Y / N	(12) Blood/Lymph	Y / N
				(13) Immunologic	Y / N

Please Explain if yes (List Item number)

item ___ ______________________________________

item ___ ______________________________________

item ___ ______________________________________

Diabetes Y / N Type:______________ Date of Diagnosis:_______/________/ (Format: mm/dd/yyyy)

Allergies Y / N Allergic to? ____________ What happens? ______________________

Medication allergies Y / N What happens? ______________________ Headaches? Y / N

Other Health problem Y / N ______________________________________

Current Medication(s) : ______________________________________

Have you had any operations? Y / N Type/ Year: ______________________________________

Do you use: Cigarettes/Tobacco Y / N Alcohol Y / N Other Substances Y / N

Name of Family Doctor: ______________________ Phone: (________)______________________

Date of Last Visit: ____/_____/________ (Format: mm/dd/yyyy) Date of Last Tetanus Shot: ____/_____/______ (Format: mm/dd/yyyy)

Family History

High Blood Pressure?	Y / N	Relationship(s)__________	Macular Degeneration?	Y / N	Relationship(s)__________
Diabetes?	Y / N	Relationship(s)__________	Retinal Detachment?	Y / N	Relationship(s)__________
Glaucoma?	Y / N	Relationship(s)__________	Cataracts?	Y / N	Relationship(s)__________
Other Eye Conditions?	Y / N	Relationship(s)__________	Other Eye Conditions:	Y / N	Relationship(s)__________

Please Continue On The Other Side

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Eye Level Inc.

Patient History Questionnaire (continued)

Personal Eye Information

Have you had any eye operations? Y / N Describe: ____________________

Have you had any eye injuries? Y / N Describe: ____________________

Do you have Glaucoma? Y / N Cataracts? Y / N Dry eyes? Y / N Blurred Vision Y / N

Other eye problems: Y / N Describe: ____________________

Do you wear glasses? Y / N Contacts? Y / N Type: ____________________

Additional information: ____________________

Whom may we thank for referring you? ____________________

Dr. Initials: ____________

Patient Responsibility Statement

Today's Date: ______/______/________ (Format: mm/dd/yyyy)

I, ____________________________________, understand that I am seeing:

Please Print Full Name

☐ **Dr. Karikomi** ☐ **Dr. Barabas** ☐ **Dr. Drey**

With / without:

Circle one

- Verification of eligibility of Insurance:
  1. VSP
  2. EyeMed
  3. Self-Pay
  4. Other (please state name) ____________________
- Medical Insurance:
  1. Aetna
  2. Blue Cross/Blue Shield PPO
  3. Other (please state name) ____________________

I understand that if my medical insurance and/or vision care plan cannot be verified before seeing the doctor, I will be financially responsible for payment of all charges incurred for services received from doctor's office at the time of service.

____________________ ___/___/___ ____________________ ___/___/______

Patient Signature Date Parent/Guardian Signature (if minor) Date

CONSENT TO PROCEDURES

☐ I consent to the Glaucoma Detection Package

☐ I do not consent to the Glaucoma Detection Package

____________________ ___/___/______

Patient Signature Date

HIPAA COMPLIANCY

I acknowledge that I received a copy of Dr. Alan Karikomi's Notice of Privacy Practices

____________________ ___/___/______

Patient Signature Date

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