# NEW PATIENT HISTORY QUESTIONNAIRE

**Thank you for choosing Utopia Optometry for your vision care. In order to provide you with the best care possible, we ask that you answer the questions below. If you prefer, we will be happy to sit down with you to help you complete this form. We are here to assist you!**

**Name:** _____ **Date:** _____/_____/_____
(First) (M.I.) (Last)

**I prefer to be called:** _____ **Date of Birth:** _____/_____/_____ **Age:** _____ **Occupation:** _____

**Address:** _____ **Apt#**_____ **City:** _____ **State:** _____ **Zip:** _____

**Phone (c):** (_____)_____ **Phone (h):** (_____)_____ **Phone (w):** (_____)_____

**Emergency contact:** _____ **Relationship:** _____ **Phone:** _____

**E-mail:**_____ **Social Security #** _____/_____/_____

**How did you find us?** □ **insurance/provider list** □ **drive/walk by** □ **friend/family** _____ □ **other**_____

## REQUIRED INSURANCE INFORMATION:

**EMPLOYMENT STATUS:** □ **full-time** □ **part-time** □ **not employed** □ **student, full-time** □ **student, part-time** □ **active duty, military**

**IF YOUR INSURANCE POLICY IS NOT IN YOUR NAME, PLEASE PROVIDE THE FOLLOWING:**

**POLICYHOLDER'S NAME:** _____ **POLICYHOLDER'S DATE OF BIRTH:** _____/_____/_____

**POLICYHOLDER'S ADDRESS:** □ **same as above OR fill out below:**

**Address:** _____ **City:**_____ **State:**_____ **Zip:**_____

## PATIENT MEDICAL INFORMATION

**Many systemic health conditions, as well as medications, can have an impact on the health of your eyes. Please complete the following information so your doctor can provide you with the most thorough care and evaluation of your eye health.**

**Have you had any ongoing problems with any of the following systems? Please check (√) all that apply:**

| | | | | | |
|---|---|---|---|---|---|
| _____ | nervous system | _____ | ears/nose/throat | _____ | endocrine/glands/thyroid |
| _____ | headaches/migraines/seizure | _____ | gastrointestinal | _____ | blood/lymphatic |
| _____ | respiratory | _____ | genitals/kidney/bladder | _____ | allergic/immunologic |
| _____ | cardiovascular/heart disease | _____ | muscles/bones | _____ | psychiatric/psychological |
| _____ | high blood pressure | _____ | integument/skin | _____ | cancer |

_____ **diabetes (if yes, date of diagnosis:** _____) □ **Type I** □ **Type II**

**Please explain:** _____

**Other health problems:** _____

**Are you currently taking medication?** □ **y** □ **n If yes, please list:** _____

**Are you allergic to medication?** □ **y** □ **n Please list:** _____

**Do you use cigarettes/tobacco?** □ **y** □ **n** **Do you drink alcohol?** □ **y** □ **n** **Do you use illegal drug?** □ **y** □ **n**

**Name of primary care physician:** _____ **Date of last visit:** _____

** CONTINUED ON OTHER SIDE **

**PATIENT'S EYE HISTORY**

Date of last eye exam _____ By whom? _____Dilated? □ y □ n

Do you wear glasses? □ y □ n Do you wear contact lenses? □ y □ n If yes, □ soft □ rgp/hard

Please check any of the following conditions you have/had: _____ crossed eye/lazy eye _____ dry eyes _____ cataracts

_____ glaucoma _____ macular degeneration _____ retinal detachment _____other _____

Do you have any other eye conditions or problems? If so, describe _____

Have you had a serious eye injury or eye surgery? If yes, please describe _____

_____date?: _____

Are you using any eye drops (prescription or over-the-counter)? Please list: _____

Please describe any problems with your eyes for which you are seeking treatment today: _____

_____

Check all that apply: □ itchy eyes □ stinging/burning □ flashes/floaters □ eyestrain/eye fatigue □ blurry vision □ red eyes

Are you planning to purchase new glasses today? □ yes □ no

Are you considering LASIK / refractive surgery? □ yes, I'd like to discuss it □ no

**FAMILY EYE & MEDICAL HISTORY**

Please check (√) any conditions that have occurred in your immediate family:

| | | | | | |
|---|---|---|---|---|---|
| _____ | glaucoma | relation_____ | _____ | diabetes | relation_____ |
| _____ | macular degeneration | relation_____ | _____ | heart disease | relation_____ |
| _____ | retinal detachment | relation_____ | _____ | lupus | relation_____ |
| _____ | crossed eye/lazy eye | relation_____ | _____ | other _____ | relation_____ |

In order to assist us in processing your insurance claim and to allow for communication with your other health care providers, please read and sign the following:

I authorize Utopia Optometry to bill my insurance carrier on my behalf. I request that payment of authorized insurance benefits be made to this clinic for any services furnished me by this doctor/clinic. I understand that I am financially responsible for any balance not covered by my insurance carrier, and that a quotation of benefits is not a guarantee of coverage. A copy of this signature is valid as the original. I authorize any holder of medical information about me to release to my medical insurance carrier any information needed to determine the benefits payable for related services for myself and/or my dependents.

Patient/guardian:_____

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION:**

I authorize the release of medical information regarding myself/my dependents and my current condition to my referring, consulting, or treating physicians.

Patient/guardian: _____

**NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT:**

We keep a record of the health care services we provide to you. You may request a copy of your medical record in writing. We will not disclose your record to others unless you direct us to do so or unless legal authorities authorize or compel us to do so. Our Notice of Privacy Practices is available at the reception desk and is posted in the clinic. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information. You are entitled to a copy of this Notice and it is available at your request.

I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act.

Patient/guardian: _____

FOR DOCTOR'S USE ONLY: This form was reviewed by _____ date: _____