



SILICON VALLEY EYE PHYSICIANS

General Health and Medical Questionnaire

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M or F Primary Care Physician: \_\_\_\_\_

Occupation: \_\_\_\_\_ (New Patients): Date Of Last Eye Exam \_\_\_\_\_

PATIENT HISTORY \*\* Use back if necessary

List any medications: include all prescriptions and non-prescriptions (ex: aspirin)?

Are you allergic to any medications? Yes or No (If yes, specify) \_\_\_\_\_

List all major illnesses or injuries (glaucoma, diabetes, high blood pressure, heart attack, concussion, etc.)

List any surgeries you have had: (cataract, appendectomy)

Have you ever had a blood transfusion? Yes No Do you wear glasses? Yes No Contacts? Yes No

Table with 4 columns: Do you have problems in the following areas?, No, Yes, Details. Rows include: Females: pregnant, nursing; General Constitution: fever, weight loss or gain, tired, etc.; Ears, Nose, Throat: stuffy nose, ear ache, cough, dry mouth, hard of hearing, etc.; Cardiovascular: high blood pressure, racing pulse, etc.; Respiratory: congestion, wheezing short of breath, etc.; Gastrointestinal: stomach upset, diarrhea, constipation, hernia, ulcers, etc.; Genital, Kidney, Bladder: painful, frequent urination, impotence, jaundice, etc.; Muscles, Bones, Joints: pain, stiffness, swelling, cramps, arthritis, etc.; Skin: acne, warts, growths, rash, etc.; Neurological: numbness, headache, seizures, paralysis, etc.; Psychiatric: anxiety, depression, insomnia, etc.; Endocrine: diabetes, hypothyroid, etc.; Blood, Lymph: bleeding, high cholesterol, anemia related to transfusion, etc.; Allergic, Immunologic: sneezing, swelling, redness, itching, hives, lupus, etc.

FAMILY HISTORY

Has any member of your family had any of these diseases? (check all that apply) Yes No Unknown
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other inheritable disease:

SOCIAL HISTORY

Does your vision with correction limit any daily living (driving, reading, sports, work, hobbies, etc.)? Yes No
Do you drink alcohol? No Yes occasional 1 day 2-3 day 4+ day
Do you smoke? No Yes occasional 1/2 pack day 1 pack day 1+ pack day

### Silicon Valley Eye Physicians- Patient Registration

Patient's Title:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss	Evening phone	
First Name		Work phone	
Middle Initial		Cell Phone	
Last Name		Social Security #	
Nickname		Employer	
Birth Date & Sex		Occupation	
Street Address		Family/ Primary Dr	
City, State, Zip		Drivers License #	

Do you speak English fluently? Yes No - If not, what language do you speak primarily?

Who may we thank for referring you?

E-mail address ( We won't give this out! Our communications only) :

How did you hear about us?  
 Dr.  Friend  Family  Insurance  Paper  Phone book  Radio  TV  Magazine  Website  Employer  Mailing

#### Medical Insurance Information

Primary Medical Ins.	Secondary Medical Ins
ID Number	ID Number
Group Number	Group Number
Subscriber name	Subscriber name
Subscriber birth date	Subscriber birth date

#### Vision Insurance Information

Primary Vision Ins.	Secondary Vision Ins.
ID Number	ID Number
Subscriber name	Subscriber name
Subscriber birth date	Subscriber birth date

**Minor Patient:** I give consent and authorize Silicon Valley Eye Physicians to examine and provide treatment deemed advisable for this minor. Mother  Father  Guardian

**Insurance Authorization and Financial Agreement:** I hereby authorize Silicon Valley Eye Physicians to release my information to determine the benefits payable for related services to any insurance carrier I have. I hereby authorize payment directly to Silicon Valley Eye Physicians. I understand that I am responsible for any amount not covered by insurance including deductible, coinsurance, and non-covered services. (For copayments due at the time of service I understand there is a fee of \$10 if I request to be billed for this) This assignment will remain in effect until revoked by me in writing. I agree it is the patient's responsibility to know which providers are in their network and which services are covered by their plan.

**Privacy Notice:** I have received the Notice of Privacy Practices attached. I hereby authorize the physicians and staff of Silicon Valley Eye Physicians to convey information about my health to the following people:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

BY INITIALING THIS AREA YOU ARE INDICATING THAT YOU HAVE READ THE NOTICE OF PRIVACY AND UNDERSTAND THE ABOVE STATEMENTS

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_