# OPTICS Medical History Record
# Notice of Privacy Practices Acknowledgement

Please **print** all information Appointment Date_____

Patient's Name_____ Birth Date_____ M or F

Street Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Employer_____ Occupation_____ Email_____

Emergency Contact_____ Phone Number_____

Date of Last Eye Exam_____ Name of Previous Eye Doctor_____

Referred by_____

**Personal Medical Information: Do you have problems with any of these systems? If yes, please check.**

___ Gastrointestinal ___ Nervous System ___ Mental
___ Ear/Nose/Throat ___ Genitourinary ___ Endocrine (Glands)
___ Cardiovascular ___ Musculoskeletal ___ Blood/Lymph
___ Respiratory ___ Skin ___ Allergic/Immunologic
___ Headaches ___ Surgeries (what type & when)_____

Are you in good health? Yes ___ No ___ Name of general physician_____

Any allergic reactions to medications or other substances? Yes ___ No ___
If yes, please list_____

**Please check Yes or No**

Do you smoke? Yes ___ No ___ How much?_____
Do you drink alcohol? Yes ___ No ___ How much?_____
Do you take medications? Yes ___ No ___ Please list names & how often_____
_____
Do you use other substances? Yes ___ No ___

**Do you have family history of any of the following? If yes, please check.**

___ Diabetes ___ Glaucoma ___ High blood pressure
___ Macular Degeneration ___ Retinal Detachment ___ Cataracts

Please explain which family member of any boxes you have checked_____

**Do you have any of the following? If yes, please check.**

___ Dry Eyes ___ Eye Surgeries ___ Wear Glasses
___ Blurred Vision ___ Eye Injuries ___ Wear Contacts

Any eye problems at this time? Please explain_____
Are you interested in laser vision correction? Yes ___ No ___

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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, 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,* and have reviewed all information above and it is correct to the best of my knowledge.

Patient or Guardian Signature _____ Date_____