

DATE: \_\_\_\_\_

Mihir Parikh, MD

NAME: (Mr.Mrs.Ms.MissDr): \_\_\_\_\_

**Patient  
Questionnaire**

HOW WOULD YOU LIKE TO BE ADDRESSED: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ MALE / FEMALE

SOCIAL SECURITY #: \_\_\_\_\_ MARRIED / SINGLE

HOME ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE (\_\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_\_) \_\_\_\_\_

FAX (\_\_\_\_\_) \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

EMPLOYED BY: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

WORK PHONE: (\_\_\_\_\_) \_\_\_\_\_

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? \_\_\_\_\_

PHONE #: (\_\_\_\_\_) \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

NAME OF YOUR: PRIMARY PHYSICIAN: \_\_\_\_\_ PHONE #: (\_\_\_\_\_) \_\_\_\_\_

CURRENT EYE DOCTOR: \_\_\_\_\_ LAST EYE EXAM: \_\_\_\_\_

DID YOUR EYE DOCTOR REFER YOU TO OUR OFFICE?  YES  NO

DO YOU WANT YOUR EYE DOCTOR TO PERFORM YOUR PRE & POST-PERATIVE LASIK CARE?  YES  
 NO

DO YOU WANT YOUR EYE DOCTOR TO PERFORM YOUR PRE & POST-OPERATIVE LASIK CARE?   
YES  NO

PRIMARY TYPE OF CORRECTIVE LENS WEAR:  GLASSES  CONTACT LENSES  BOTH

TYPE OF GLASSES:  SINGLE VISION  PROGRESSIVE BIFOCAL  CONVENTIONAL BIFOCAL   
TRIFOCAL

HOW LONG? \_\_\_\_\_ DISSATISFIED WITH GLASSES BECAUSE: \_\_\_\_\_  
\_\_\_\_\_

TYPE OF CONTACT LENSES:  SOFT  HARD  GAS PERMEABLE  TORICS

HOW LONG? \_\_\_\_\_ DISSATISFIED WITH CONTACTS BECAUSE: \_\_\_\_\_

### MEDICAL HISTORY QUESTIONNAIRE

### MEDICAL HISTORY QUESTIONNAIRE

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

Date of **birth** \_\_\_\_\_ Date of **last eye exam** \_\_\_\_\_

List any **medications** you currently take (prescription and over-the-counter):

\_\_\_\_\_

Do you have **allergies** to any medications?  YES  NO

If YES, list the medications:

\_\_\_\_\_

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

\_\_\_\_\_

List any **previous eye surgeries** you have had (Lasik, PRK, RK, cataract):

\_\_\_\_\_

List any **previous cosmetic surgeries** you have had:

\_\_\_\_\_

List any **general surgeries** you have had (tonsillectomy, appendectomy):

\_\_\_\_\_

Do you **currently** have any problems in the following areas? If "YES", please provide information.

	YES	NO	Explanation of Problem
--	-----	----	------------------------

<b>EYES</b>			
<b>GENERAL/CONSTITUTIONAL</b>			
<b>EARS, NOSE, THROAT</b>			
<b>CARDIOVASCULAR</b>			
<b>RESPIRATORY</b>			
<b>GASTROINTESTINAL</b>			
<b>GENITAL, KIDNEY, BLADDER</b>			
<b>MUSCLES, BONES, JOINTS</b>			
<b>SKIN</b>			
<b>NEUROLOGICAL</b>			
<b>PSYCHIATRIC</b>			
<b>ENDOCRINE</b>			
<b>BLOOD, LYMPH</b>			
<b>ALLERGIC, IMMUNOLOGIC</b>			

**FAMILY HISTORY**

Family medical history: (mother, father, sibling, grandparent)?  YES  NO  
 If YES, describe \_\_\_\_\_

**SOCIAL HISTORY**

Recreational hobbies: \_\_\_\_\_  
 Education (high school, vocational school, college degree): \_\_\_\_\_  
 Do you drive?  YES  NO  
 Do you have visual difficulty when driving?  YES  NO  
 Do you have problems with night vision?  YES  NO  
 Do you drink alcohol?  YES  NO If YES: occasional 1 per day 2-3 /day 4+ /day  
 Do you smoke?  YES  NO If YES: occasional ½ pack/day 1 pack/day 1+ pack  
 History reviewed.  No Changes.  Additions as noted above.  
 Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

S:\CCG\_Forms\Medical History Questionnaire.doc

**Acknowledgement of Receipt of AOI Notice of Privacy Practices**

I hereby acknowledge receipt of the Advanced Ophthalmology Institute (AOI) Notice of Privacy Practices at:

Advanced Ophthalmology Institute  
 4150 Regents Park Row, Suite 155  
 La Jolla, California 92037

\_\_\_\_\_  
 Signature of Patient

\_\_\_\_\_  
 Date

\_\_\_\_\_  
Signature of Patient Representative  
(State relationship to Patient)  
Or witness (if signature is thumb print or mark)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature and Title of AOI Employee

\_\_\_\_\_  
Date

**For patients unable to Acknowledge Receipt**

I hereby certify that the patient was unable to acknowledge receipt of the AOI Notice of Practices because:

\_\_\_\_\_

\_\_\_\_\_  
Signature of AOI Staff

\_\_\_\_\_  
Date