

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: _____

NAME OF YOUR: PRIMARY PHYSICIAN: _____ PHONE #: (_____) _____

CURRENT EYE DOCTOR: _____ LAST EYE EXAM: _____

HOW DID YOU HEAR ABOUT US? _____ REFERRED BY: _____

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

ARE YOU INTERESTED IN LASIK? YES NO

IF YES, PLEASE ANSWER THE QUESTIONS

BELOW:

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

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

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