

La Jolla Optique

**Patient
Questionnaire**

DATE: _____

NAME: (Mr.Mrs.Ms.MissDr): _____

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

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

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
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 1/2 pack/day 1 pack/day 1+ pack

History reviewed. No Changes. Additions as noted above.

Physician's Signature: _____

Date: _____

Acknowledgement of Receipt of La Jolla Optique Notice of Privacy Practices

I hereby acknowledge receipt of the La Jolla Optique Notice of Privacy Practices at:

La Jolla Optique
4130 La Jolla Village Drive #102
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 LJO Employee

Date

For patients unable to Acknowledge Receipt

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

Signature of LJO Staff

Date