Chart #_____ MEDICAL QUESTIONNAIRE \ EYE HISTORY

Page # ____

NAME_____ Birth date____/____/____ Age____

Month Day Year

PRESENT EYE HISTORY. Chief eye complain?_____

Duration of this problem?_____Chronic? |__|YES |__|NO Progressive? |__|YES |__|NO

Check or mark with an **X** if you have any of these **eye symptoms:** Black spots__ Light flashes__ Shadows ___

Loss of vision ___Blurred vision ___Distorted vision(halos) ___Loss of side vision ___Double vision ___**Headaches** ___

Fluctuating visual acuity ___Dryness ___Eye discharge ____Redness ___Sandy or gritty feeling ___Itching ___

Sinusitis____

Burning ___Foreign body sensation ___Tearing ___Glare/light sensitivity ___Eye pain ___Tired eyes___Sties, Cyst, Lumps___

If **X,**

explain(How long,etc)_____

_____

PAST EYE HISTORY. Date last eye exam?_____Where or Eye Doctor?_____

Do you wear **glasses?** ___ If **YES**, last time changed?_____ Are you **considering contact lenses?**_____

Do you wear **contact lenses?** ___If **YES,** last time changed?_____ Daily wear?___ Extended wear ?___Color lenses?___

Any **eye diseases?** ___ If **YES**, name?_____Cataracts?___Glaucoma?___?Infections?___Allergies?___

Any **eye surgeries?** Yes__ No__ If **Yes,** type of surgery, when,where,surgeon?_____

_____

If you use eye medications,

Which ones ? _____

MEDICAL AND SOCIAL HISTORY. Your family doctor's name?_____ City?_____

Do you **smoke?** Yes - No ; **Drink alcohol?** Yes - No ; **Occupation:**_____ **Student?** Yes - No

List *ALL* **systemic medications** presently taking- **(diet pills?)** _____

_____

Allergies? _____

Other **general surgery or illness, or hospitalization ?**_____

_____

Who in your family has had: Diabetes - Cataracts - Glaucoma - Blindness - Macular degeneration - Hypertension - Heart attacks - Stroke - Cancer - Other

FAMILYHISTORY:

_____

REVIEW OF SYSTEMS : Mark with an **X** if you have any of the following:

Fever__weight__loss__gain__weight fatigue___muscleaches__jointpain___jointswelling__**arthritis**__hearingloss tinnitus_earaches___sinuses___teeth/gums problems___eczema___psoriasis___skin rashes___Heart attack___palpitations___chest pain___**Diabetes**___Thyroid___**HighBloodPressure**___aneurysm___clots___bruising___lowbloodcount___Asthma___emphysema wheesing___cough___numbness___weakness___paralysis___stomach/duodenal ulcers___heartburn___constipation Kidney stones___bladder/prostate problems___urination problems __**Depression** **Remaining systems WNL**_.

If X mark explain,___

How long and if receiving treatment: _____

_____ **Reviewed from**____/____/____visit - **Changes Noted:** Yes – No

CHECKED BY___(INI) Signed by Dr._____, M.D. Date:____/____/____

Reviewed by_Dr. Mendoza __ Dr. Gunzburg_ Dr. Gonzalez

CHART #_____ NS._____ PVT MR MD MRD REFR Y N

LUIS MENDOZA, MD

WELCOME TO

ALLISON GUNZBURG, MD

CLIFTON_, PASSAIC_, EYE SPECIALISTS

CARMEN GONZALEZ, MD

PATIENT REGISTRATION FORM

Have you been a patient of our practice? ☐ Yes ☐ No - **Recommended by:** ☐ Dr._____ ☐ Insur ☐ Relative ☐ Friend

Method of Personal Payment: ☐ Cash ☐ Check - if by Check Drivers License number_____

CELLULAR (_____) _____-_____

Patient: FIRST NAME MI LAST NAME ☐ FEMALE BIRTH DATE AGE HOME PHONE

☐ MALE ____/____/____ |____| (_____)_____

Month Day Year

_____ MARITAL STATUS

☐ Single ☐ Married EMPLOYED RETIRED DISABLED

☐ Divorced ☐ Separated ☐ YES ☐NO ☐ YES ☐ NO ☐ YES ☐ NO

_____ ☐ Widow ☐ Widower

PROFESSION OR JOB_____

Street_____

ADDRESS

SOCIAL SECURITY No_____

_____

CITY STATE ZIP

E-MAIL _____

_____

NAME , ADDRESS AND PHONE OF YOUR PLACE OF WORK IF YOU ARE OVER 18 YR-OLD AND FULL TIME STUDENT SCHOOL NAME AND ADDRESS

WHO CAN WE CONTACT IF WE ARE UNABLE TO REACH YOU? _____ RELATIONSHIP_____

INSURANCE INFORMATION: DO YOU HAVE A **CURRENT** HEALTH INSURANCE? ___YES ; ___NO

DO YOU HAVE MORE **THAN ONE** HEALTH INSURANCE? ___YES ; ___NO

DEDUCTIBLE: NO_, IF YES_, HOW MUCH $_____

PRIMARY INSURANCE:_____ STARTING DATE:_____/_____/_____

SECONDARY / GAP/ SUPPLEMENTARY INSURANCE::_____STARTING DATE:_____/_____/_____

IS YOUR INSURANCE THROUGH: ___YOUR EMPLOYER; ___HUSBAND; ___WIFE; ___FATHER; ___MOTHER; OR ___SELF

UNIFORM ASSIGNMENT, RESPONSIBILITY OF PAYMENTS AND RELEASE OF INFORMATION STATEMENT

I hereby assign or transfer benefits made to me or on my behalf to Dr. Mendoza, Dr. Gunzburg, Dr. Gonzalez, for any services furnished to me by any of these physicians. I further agree that I am responsible for payment of charges incurred by me that are outside of the scope of my insurance coverage or for which my insurance company has paid me. **I agree that any insurance payments sent to me that belongs to any of the doctors I will bring to the office immediately.**

I hereby authorize Dr. Mendoza, Dr. Gunzburg, Dr. Gonzalez to release information acquired during the course of my examination or treatment to my referring physician or to an appropriate insurance carrier. If a Medicare patient, I further authorize release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services.

Responsible party or Patient's Signature_____

CHECKED BY_____ (INI)

Date_____