MEDICAL HISTORY QUESTIONNAIRE **Todays Date:**_____

Name: _____ Nickname: _____ Date of Birth: ____/____/_____

Social Security Number:_____-_____-_____ Gender: Male or Female (circle one) Age:_____

Mailing Address:_____City:_____State:_____Zip:_____

Physical Address:_____City:_____State:_____Zip:_____

Email:_____Home Phone:_____Cell:_____

Primary Care Physician: _____Referring /Specialty Dr._____

Pharmacy:_____ Location(street & city) _____

Emergency Contact: Name:_____Phone:_____Relationship:_____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish

Allergies:	**Reaction**	**Severity**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Past Ocular History: (Please mark all that apply) □ No history of eye problems

□ Cataracts □ Hyperopia (Far sighted) □ Myopia (Near sighted) □ Amblyopia (Lazy eye)
□ Diabetic Retinopathy □ Iritis □ Optic Neuritis □ Aphakia
□ Dry Eyes □ Keratoconus □ Retinal Detachment □ Astigmatism
□ Glaucoma □ Macular Degeneration

Other_____

Ocular Surgeries: (Please mark all that apply) □ No prior ocular surgery

R - L	R - L	R - L	R - L
□ □ Foreign Body Removal	□ □ Punctal Plugs	□ □ Laser	□ □ Cataract Surgery
□ □ Blepharoplasty	□ □ Retinal Laser Surgery	□ □ RK	□ □ LASIK
□ □ Strabismus Surgery	□ □ Vitrectomy	□ □ Corneal Transplant	□ □ PRK (eye muscle surgery)

Other_____

Current Eye Medications: (Please list)

_____ _____ _____

_____ _____ _____

Other Medical History: □ No history of illnesses

□ Thyroid Disease □ Congestive Heart Failure □ Headache □ Lung Disease
□ Anemia □ COPD □ High Blood Pressure □ Lupus
□ Arthritis □ Diabetes Type 1 □ High Cholesterol □ Migraine
□ Arrhythmia □ Diabetes Type 2 □ HIV/ AIDS □ Polymyalgia
□ Asthma □ Eczema □ Kidney Disease □ Psychiatric Disorder
□ Bleeding Disorder □ Fibromyalgia □ Kidney Stones □ Skin Cancer
□ Cancer □ Hearing Loss □ Liver Disease □ Stroke
□ Chicken Pox □ Herpes Zoster / Shingles □ Meningitis □ Toxoplasmosis
□ Hepatitis A / B / C □ Histoplasmosis □ MRSA □ Wound Infection
□ Herpes Simplex □ Syphillis

Other_____

General Surgeries / Operations: (Please list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

All Other Medications: (Please list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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Family History:

- □ Arthritis
- □ Blindness
- □ Cancer
- □ Cataracts
- □ Diabetes
- □ Glaucoma
- □ Heart Disease
- □ High Blood Pressure
- □ Kidney Disease
- □ Lazy Eye
- □ Macular Degeneration
- □ Retinal Disease
- □ Stroke
- □ TB

Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often?_____

Drug Use: □ Yes □ No If yes what and how often?_____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymphnodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

KAZI OPHTHALMOLOGY

INSURANCE INFORMATION/HIPPA

[ ] MEDICARE #_____

[ ] MEDICAID#_____

[ ] OTHER MEDICAL INSURANCE _____

ID #_____ GROUP #_____

POLICY HOLDER_____ DOB_____

[ ] VISION INSURANCE_____ ID# _____

POLICY HOLDER_____ DOB _____

[ ] WORKERS COMPENSATION _____

Are you personally responsible for the payment of your fees? [ ] Yes [ ] No If not, who is?

Name _____ Relationship _____DOB_____

Agreement of Responsibility

I understand that professional services, diagnostic tests and other medical services rendered to the patient are the financial responsibility of the patient or the patient's guarantor (the responsible party in the case of minors). I understand that I am financially responsible for all charges not covered by my insurance company.

Eyeglass Prescription (Refraction): I understand that a refraction is a service that is not covered by Medicare or most health insurance carriers. If your doctor provides a refraction with an eyeglass prescription, you will be responsible for this charge, which is payable at the time of service ($25.00).

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his or her judgment.

Release of Information Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to any of my insurance companies. I permit a copy of this to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement in disputed claims. I assign any rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

I hereby authorize **KAZI OPHTHALMOLOGY**, its agents, employees and affiliates to have access to my complete medical records for the purpose of performing its billing and management functions as they deem necessary.

This agreement is in effect until revoked in writing by the patient.

Patient Name: _____

Patient(Guarantor) Signature/Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices.

By signing below I acknowledge receipt of HIPPA Privacy Notice from **KAZI OPHTHALMOLOGY.**

Patient Name: _____ DOB: _____

I authorize the office of Abdul A. Kazi M.D. to communicate with the following individuals regarding my condition or course of treatment.

Name: _____ Relation: _____

Phone:_____

Name: _____ Relation: _____

Phone:_____

I authorize the office of **KAZI OPHTHALMOLOGY** to communicate confidential information to me including invoices for service to the following address and/or telephone number:

Mailing Address: _____

Phone: _____

Patient(Guarantor) Signature/Date _____