Dr. Paulina TuQuyen Han

NAME: ____________________ **BIRTHDATE:** ____________

ADDRESS: ____________________ **SEX:** M / F

CITY: ____________________ **STATE:** ________ **ZIP:** ____________

Home Phone: ____________________ **Social Security #:** ____________________

Cell Phone: ____________________ **Occupation:** ____________________

May We Text You: Y / N **Marital Status:** Single / Married / Divorced / Widowed

Email: ____________________ **Whom May We Thank For Referring You:** ____________

Emergency Contact: ____________________ **Communication Preferred:** Email / Text / Phone / Postal

Preferred Language: ____________________

Race: Native American/Native Alaskan / Hawaiian/Other Pacific Islander / Black/African American
Caucasian / Hispanic / Asian / Other: ____________________

Ethnicity: Hawaiian/Other Pacific Islander / Hispanic/Latino / Not Hispanic/Latino

INSURANCE INFORMATION: NONE / VSP / Eyemed / Davis Vision / MES / Medicare / Medi-Cal / Other: ______

Are you the primary member of this insurance: YES / NO

If **NO**, please indicate member's name, date of birth, and ssn #: ____________________

Reason for today's visit: Medical Visit Annual Exam Other: ____________________

Date of last eye exam: ____________________ **Date of last dilation:** ____________________

Please circle all that apply to you:

Blurred Vision	Fluctuation in vision	Tired eyes	Flashes / Floaters
Dry eyes	Had LASIK	Eye rubbing	Body fatigue
Lazy eye	When: ________	Itchy eyes	Reduced concentration
Light sensitivity	Poor night vision	Headaches	Double vision

Do you use a smartphone / tablet / computer / read books (please circle all that applies):
If **YES**, about how many hours per day do you perform each activity? ____________________

If you are getting contact lenses today, please circle the answer that applies to you:

First time wearer Previous wearer What type of lenses do you wear: Hard / Soft: ____________

DILATION makes your pupils large so that the doctor can get a better view of the internal eye health. It may cause blurry vision at near with increased light sensitivity for 3-5 hours. The effect will vary with different patients. If you are diabetic, have high blood pressure or high cholesterol, are very near-sighted, are taking certain medications, or have not had your eyes dilated in the past 2-3 years, we strongly recommend dilation. **Do you wish to have your eyes dilated?** YES / NO

RETINAL PHOTOGRAPHY assists in the detection and management of conditions such as macular degeneration, hypertensive retinopathy, optic nerve disease, diabetic changes and retinal holes or thinning. It is also used to document abnormalities of disease affecting the eye. **Do you wish to have us perform retinal photography on you? ($29)** YES / NO

I authorize the release of any medical or other information necessary to process this claim. I understand that I am financially responsible for all charges not paid for by my insurance. I also acknowledge that I have been given the Notice of Privacy Practices form, and understand the terms of the HIPPA Compliance.

Signature: ____________________ **Date:** ____________

Parent or Guardian's Name (If minor): ____________________

Relationship of Patient Representative to Patient: ____________________

PATIENT HEALTH HISTORY

NAME: ______________________________ **BIRTHDATE:** ____________

PRIMARY CARE PHYSICIAN: ________________ **DATE OF LAST EXAM:** ____________

MEDICAL/FAMILY HISTORY (if more space is needed, please let us know):

Please list all your current medications (include over the counter, vitamins, and herbal therapy): ____________

____

____

List all major surgeries (eye surgery included): ______________________________

____

List any allergic reactions to medications or eye drops: ______________________________

____

Please indicate if any of the conditions apply to you or a family member:

Disease/Condition	**Yourself** YES	NO	**Family Member** YES	NO	**Relationship (blood relatives)**
Cataract / Blindness	•	•	•	•	____________
Eye Turn	•	•	•	•	____________
Glaucoma	•	•	•	•	____________
Macular Degeneration	•	•	•	•	____________
Retinal Detachment	•	•	•	•	____________
High Blood Pressure	•	•	•	•	____________
High Blood Cholesterol	•	•	•	•	____________
Diabetes	•	•	•	•	____________

Other: ______________________________

Women: Are you pregnant? YES / NO   Breastfeeding? YES / NO

<u>**Review of Systems**</u>: Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic
- Lupus (SLE)
- Rheumatoid Arthritis
- Seasonal Allergies

Cardiovascular
- High Blood Pressure
- High Blood Cholesterol
- Heart Disease
- Vascular Disease

Constitutional
- Weight loss / gain
- Fever
- Fatigue
- Trauma

Endocrine/Glands
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction

Gastrointestinal
- Crohn's Disease
- Colitis
- Acid Reflux / Ulcer
- Gout

Genital/Urinary
- Urinary Tract Infection
- HIV Positive
- Herpes / Chlamydia

Ear, Nose, and Throat
- Sinusitis
- Upper Respiratory Tract Infection

Hematologic/Lymphatic
- Anemia
- Leukemia
- Bleeding Disorder

Skin/Integumentary
- Eczema
- Rosacea
- Psoriasis

Muscle/Skeletal
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis

Neurological
- Multiple Sclerosis
- Epilepsy
- Tremors

Psychiatric
- Depression
- Bi-Polar
- Schizophrenia

Social
- Tobacco Use: Never _______ Current _______ Former _______ When _______
- Non-Prescription Drugs: YES / NO ______________________
- Alcohol Consumption: None _______ Social _______ Heavy _______

Respiratory
- Asthma
- Bronchitis
- Emphysema

List any other conditions you may have that are not listed above: ______________________

- If you do not have any conditions, please circle **NONE** here.

Please sign below to certify that the information is current and up-to-date, and that you have answered the above questions to the best of your knowledge:

Signature: ____________________ **Date:** ____________ **Doctor's Initials:** ________