Advanced Optical / Kim Doan, M.D.

351 Hospital Rd #100, Newport Beach, CA 92663 Phone: 949.645.6300 Fax: 949.645.6020

Welcome to Advanced Optical and thank you for choosing us for your eye health and vision care needs. In order to prepare for your evaluation and for us to provide you with the best care for your individual needs, please review and complete the attached forms.

General Information

Last Name: _____ First Name: _____ M.I. _____

Sex☐M ☐ F Birth Date: _____ Age: ____ SSN: _____ Marital Status: ☐S ☐M ☐D ☐W

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ E-mail: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Date of Last Eye Exam: _____ Name of Previous Eye Doctor: _____

Vision Insurance Carrier: _____ Policy#: _____

How did you find out about our office? _____

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that I have certain rights to privacy regarding disclosure of my health information. I understand that this information may be used to direct treatment, payment, or health care operations. Unless I decline, relevant information may be shared with family involved in my eye care. I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I may request, in writing, to restrict how my information is shared. By signing below, I acknowledge the above and that I have reviewed or been given the opportunity to review Advanced Optical's Notice of Privacy Practices (*available on our website at www.advancedopticaleyes.com),* which further details the uses and disclosures of my health information.

Signature _____ Date _____

Financial Agreement

I understand that I am financially responsible for all charges and it is my responsibility to pay balances not paid by insurance. **I understand that most insurances do not pay for refractions (to obtain an eyeglass prescription). If I have a refraction, I am responsible for the refraction fee of $45.** Payment is due at the time services are rendered.

Signature _____ Date _____

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Medical History Questionnaire

Please check all that apply:

☐ Poor vision	☐ Loss of vision	☐ Eye pain
☐ Glaucoma	☐ Diabetic retinopathy	☐ Cataracts
☐ Dryness	☐ Excess tearing	☐ Redness
☐ Fluctuating vision	☐ Distorted vision	☐ Sandy/gritty feeling
☐ Itching	☐ Burning	☐ Drooping eyelids
☐ Soreness	☐ Glare/light sensitivity halos	☐ Other _____ (explain below)

Please **explain** any boxes you have checked:

_____

_____

_____

Do you **currently** have a problem with any of these systems? Please check all that apply:

☐ General/Constitutional
(fever, heat stroke, weight loss or gain, unusually tired, etc.)

☐ Cardiovascular
(high BP, racing pulse, etc.)

☐ Gastrointestinal
(stomach upset, diarrhea, constipation, hernia, ulcers, etc.)

☐ Musculoskeletal
(joint pain, stiffness, swelling, cramps, arthritis, etc.)

☐ Neurological
(numbness, headache, seizures, paralysis, etc.)

☐ Endocrine
(diabetes, hypothyroid, etc.)

☐ Allergic/Immunologic
(sneezing, swelling, redness, itching, hives, lupus, etc.)

☐ Ears/Nose/Throat
(hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)

☐ Respiratory
(congestion, wheezing, shortness of breath, etc.)

☐ Genital, Kidney, Bladder
(painful/frequent urination, impotence, yellow jaundice, etc.)

☐ Skin
(pimples, warts, growths, rash, etc.)

☐ Psychiatric
(anxiety, depression, insomnia, etc.)

☐ Blood/Lymph
(bleeding, cholesterolemia, anemia, etc.)

☐ Other _____
(explain below)

Please **explain** any boxes you have checked:

_____

_____

_____

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Any allergic reactions to medications or other substances (latex, etc.)? ☐Yes /☐No

If yes, please list: _____

Name of general physician: _____ Phone number: _____

Do you smoke? ☐Yes /☐No How much? _____
Do you drink alcohol? ☐Yes /☐No How much? _____
Do you take medications? ☐Yes /☐No Please list names and how often:

_____
_____
_____
_____

Do you use other substances? ☐Yes /☐No

Do you have family history of any of the following?

☐ Diabetes
☐ Glaucoma
☐ High blood pressure
☐ Macular degeneration
☐ Retinal detachment
☐ Cataracts
☐ Blindness
☐ Heart disease
☐ Stroke
☐ Cancer
☐ Thyroid disease
☐ Other heritable disease

_____

Please **explain** any boxes you have checked:

_____
_____
_____

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Vision & Lifestyle Questionnaire

Please complete this questionnaire so we can better understand your daily vision needs.

What is your occupation? _____

How many hours a day do you spend per activity?

Reading _____ Computer _____ Smart Phone _____ Tablet _____ Digital Equipment _____

Do you drive? Yes / No If so, any visual difficulties? _____

Do your eyes feel tired or strained at the end of the work day? ☐Yes /☐No
Do you experience sensitivity to light? ☐Yes /☐No
Does glare bother you? ☐Yes /☐No
Do you regularly participate in outdoor exercise? If yes, please describe: ☐Yes /☐No

_____

Do you participate in any contact sports? If yes, please describe: ☐Yes /☐No

_____

Do you wear sunglasses with UV protection? ☐Yes /☐No
Does driving at night bother you? ☐Yes /☐No

Eyewear Needs

- ☐ Daily Wear
- ☐ Driving
- ☐ Non-prescription Sunglasses
- ☐ Prescription Sunglasses
- ☐ Sport
- ☐ Safety
- ☐ Reading
- ☐ Fashion Frames
- ☐ Colored Contact Lenses

Occupational Needs

- ☐ Computer Glasses
- ☐ Protective
- ☐ Absorption
- ☐ Safety

What is important to you?

- ☐ Comfort
- ☐ Thin Lens
- ☐ Optimized Vision
- ☐ Glare Reduction
- ☐ Updating Your Look
- ☐ Backup Pair
- ☐ Current Lens Technology
- ☐ Melanoma Prevention

Please describe any additional eyewear needs you would like to address:

_____

_____

_____