CALIFORNIA
Eye Surgeons

MEDICAL HISTORY

Name: _____ Date of Birth: _____

** The following information is required by the Center of Medicare Services. Your answer will never affect your care.*

***Race**: [ ] White [ ] Black/ African- American [ ] Asian
[ ] Pacific Islander [ ] American Indian/ Eskimo [ ] Other: _____
***Ethnicity:** [ ] non-Hispanic [ ] Hispanic
***Language**: _____

REVIEW OF SYSTEMS:

What is the primary reason for today's (first) visit? _____

Do you presently have any problems in the following areas? If "YES", give an explanation.

	YES	NO	EXPLANATION OF PROBLEM
Eyes			
Loss or blurred vision	[ ]	[ ]	_____
Loss of side vision, double vision	[ ]	[ ]	_____
Redness	[ ]	[ ]	_____
Tearing, discharge	[ ]	[ ]	_____
Gritty feeling, dryness	[ ]	[ ]	_____
Glare or halos	[ ]	[ ]	_____
Light sensitivity	[ ]	[ ]	_____
Eye pain or soreness	[ ]	[ ]	_____
Floaters	[ ]	[ ]	_____
Flashes of light	[ ]	[ ]	_____
Infection of eye lashes or lid, styes	[ ]	[ ]	_____
Ears, nose, mouth, throat	[ ]	[ ]	_____
Cardiovascular (heart/ blood vessels)	[ ]	[ ]	_____
Respiratory (lungs/ breathing)	[ ]	[ ]	_____
Gastrointestinal (stomach/ intestines)	[ ]	[ ]	_____
Genitourinary (genitals/ kidney/bladder)	[ ]	[ ]	_____
Musculoskeletal (muscles/joints)	[ ]	[ ]	_____
Integument (skin/breast)	[ ]	[ ]	_____
Neurological	[ ]	[ ]	_____
Psychiatric	[ ]	[ ]	_____
Endocrine (hormones/ glands)	[ ]	[ ]	_____
Hematologic/Immunologic (blood)	[ ]	[ ]	_____
Seasonal allergies (hay fever, etc.)	[ ]	[ ]	_____

PAST HISTORY (EYE)	YES	NO	
Eye drops currently in use: (List)	[ ]	[ ]	_____

Eye drops used in the past: _____

Allergies to eye drops	[ ]	[ ]	List drops you are allergic to: _____
History of cataract, glaucoma	[ ]	[ ]	_____
History of cross/ lazy eye	[ ]	[ ]	_____
Eye injury or other disease	[ ]	[ ]	_____
Eye surgery	[ ]	[ ]	_____

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PAST HISTORY (MEDICAL)

List any medications (other than eye drops) that you are currently using: _____

_____

_____

List all major illnesses: Diabetes_____ Hypertension _____
Other: _____

_____

List any major surgical procedures: _____

_____

Do you have any medication allergies? [ ] NO [ ] YES Penicillin Sulfa
List other medication allergies: _____

_____

SOCIAL HISTORY

	YES	NO	EXPLANATION
GENERAL			
Do you drink alcohol?	[ ]	[ ]	How much do you drink per day? _____
			_____
Do you smoke?	[ ]	[ ]	When did you start smoking? _____
			_____
			How much per day? _____

Who do you live with**?** (Spouse, partner, children, friend, other) _____

What is your occupation**?** _____

OCULAR
Have you thought about refractive eye surgery (LASIK) to be rid of glasses or contact lens? _____
Vision causes problems with:
[ ] Driving [ ] Night vision [ ] Reading [ ] Sports/ Outdoor activities

FAMILY HISTORY

	YES	NO	EXPLANATION/ RELATIONSHIP
OCULAR			
Blindness	[ ]	[ ]	_____
Cataract	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Macular degeneration	[ ]	[ ]	_____
Retinal detachment	[ ]	[ ]	_____
MEDICAL			
Diabetes	[ ]	[ ]	_____
Arthritis, lupus, etc.	[ ]	[ ]	_____
Other (List)	[ ]	[ ]	_____

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Patient Name: _____ Date of Birth:_____

Gender: ❑Male ❑Female

Address: _____
City: _____ State: ____ Zip:_____
Home Phone: _____ Mobile Phone: _____
Email: _____

Primary Insured Name: _____ Date of Birth :_____
Relationship to patient: _____

Emergency Contact Name: _____ Phone number: _____
Relationship to patient: _____

Primary Care Physician: _____

Pharmacy name and location: _____

How did you hear about our clinic?

❑Referred by doctor: _____

❑Yelp ❑Google search ❑Walked-by the office

❑Medical doctor review website (Healthgrades.com, Vitals.com)

❑Friend/Family/Other: _____

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.**
2. **In order to control your cost of billing, we request that your office visit charges be paid at the conclusion of each visit, unless you are covered by Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services Administration, its agents or any insurance carrier I may have, any information needed to determine these benefits these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release all information necessary to secure the payment.
5. I grant permission for Kaur Eye Institute to view my prescription history from external sources.

Signature:_____ **Date**_____
(Patient or Legal Representative)
Name (if not patient): _____ Relationship to patient: _____

California Eye Surgeons - 555 Knowles Drive, Suite 117 - Los Gatos, CA 95032
Tel: 408.940.3930 - Fax: 408.940.3945 - www.CalEyes.com