Vista Optometry Center | Dennis Lin O.D. - 537 S. Atlantic Blvd. Monterey Park, CA 91754 - 323-264-2015

Patient Information Questionnaire

今天的日期_____/____/_____ 年龄 _____

名字:_____ 出生日期:_____/_____/_____ 社会安全号码_____/_____/_____

地址_____城市:_____ 州:_____ 邮政编码:_____

手机: (_____)_____-_____家庭电话: (_____)_____-_____工作电话:(_____)_____-_____

电子邮件:_____ 地位: □已婚 □离婚 □单身 □其他 性别: □ M □ F

首选语言: □ English □ Spanish □ 国语 □广东话 □ Vietnamese □ Other:_____

您是如何知道我们的/谁推荐我们?_____

职业_____爱好_____

紧急联络人: (如果我们无法与您联系)(如果未满18岁，需要父母或监护人信息)

名字:_____ 电话:_____ 关系:_____

最后一次体检_____/_____/_____ 医生姓名:_____ 医生电话: (_____)_____

最后一次眼科检查_____/____/_____ 眼科医生姓名:_____ 医生电话: (_____)_____

INSURANCE: Vision and Medical PPO Insurance

Vision Insurance Name:_____**Vision** Insurance Policy Number:_____

Primary's Name_____ Primary's SSN:_____ Primary's Birthdate:_____

Medical Insurance Name(**PPO only**):_____**Medical** Ins. Policy Number:_____

Primary's Name_____ Primary's SSN:_____ Primary's Birthdate:_____

I certify that the information given by me is true and correct. I certify that I, and/or my dependent(s) have insurance coverage and authorize payment of these benefits directly to Dennis Lin, O.D., Inc. on my behalf for any services and materials furnished. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim) my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Lifetime Patient Signature or legal representative **X**_____日期:_____
(Used for insurance claim submission for this office only)

HIPPA

I acknowledge the Notice of Privacy Practices(All patients will receive a copy) **X**_____日期:_____

MEDICAL HISTORY

您对药物过敏吗? □No □ Yes 如果有, 请说明 _____

_____

列出您服用的任何药物(包括口服避孕药，药丸，滴眼液，维生素，非处方药等):

_____

_____

列出您遭受过的所有重大伤害，手术和/或住院治疗以及何时?_____

_____

Check any of the following that you have had: 如果没有，请在此处标记: □

□ Crossed eyes □ Lazy eye □黄斑 □ Loss of vision □眼睛干涩 □ 眼睛过敏 □青光眼
□白内障 □视网膜疾病 □眼部感染 □ 眼部损伤 □ Others:_____

您是否怀孕和/或哺乳? □ No □ Yes
你戴眼镜吗? □ No □ Yes If yes, 你戴眼镜多久了_____
你戴隐形眼镜吗? □ No □ Yes If yes, what brand and power?_____

Last Name:_____ First Name:_____M.I.__ DOB:_____

FAMILY HEALTH AND EYE HISTORY

您家中谁都有这些情况？（父母，祖父母，兄弟姐妹，血亲）以下情况。

如果是？ 谁？请注明关系 **如果没有，请在此处标记**: □

□白内障_____ □视网膜疾病_____ □高胆固醇_____ □肾脏疾病_____
□青光眼_____ □失明_____ □甲状腺疾病_____ □癌症_____
□黄斑_____ □糖尿病_____ □关节炎_____ □红斑 _____
□Crossed Eye/Lazy Eye_____ □心脏病_____ □Other:_____ □Other:_____
□糖尿病视网膜病变_____ □高血压_____

SOCIAL HISTORY

你抽烟吗? □ No □ Yes, 多久了:_____ 你开车吗? □ No □Yes, 多久了: _____
你喝酒吗? □ No □ Yes, 多久了:_____ 你使用非法药物吗？□ No □Yes, 多久了:_____
您是否曾经接触或感染过性病: □ No □ Yes If yes: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

REVIEW OF SYSTEMS OF PATIENT MEDICAL HISTORY

您目前是否遇到过以下方面的任何问题：请检查相应的框。

System	NO	YES	?
Constitutional			
发热，体重减轻/增加	□	□	□
Integumentary (Skin)	□	□	□
Neurological			
头痛	□	□	□
偏 头痛	□	□	□
癫痫	□	□	□
Eyes*			
视力丧失	□	□	□
视力模糊			
Far, Near, Computer	□	□	□
看到眩光/光晕	□	□	□
侧视力丧失	□	□	□
复视	□	□	□
眼睛干涩/眼睛辣	□	□	□
眼睛流泪	□	□	□
眼睛粘液	□	□	□
眼睛发红	□	□	□
眼睛有沙	□	□	□
眼睛发痒	□	□	□
异物感	□	□	□
对光敏感	□	□	□
眼睛疼痛	□	□	□
慢性眼部感染	□	□	□
麦粒肿	□	□	□
飞蚊症	□	□	□
眼睛疲劳	□	□	□
Endocrine			
甲状腺	□	□	□

	NO	YES	?
Ear, Nose, Mouth, Throat			
过敏症	□	□	□
鼻塞	□	□	□
流鼻涕	□	□	□
慢性咳嗽	□	□	□
Respiratory			
哮喘	□	□	□
慢性支气管炎	□	□	□
肺气肿	□	□	□
Vascular/Cardiovascular			
糖尿病	□	□	□
高胆固醇	□	□	□
高血压	□	□	□
血管疾病	□	□	□
心脏疼痛	□	□	□
Gastrointestinal			
腹泻	□	□	□
便秘	□	□	□
Genitourinary			
肾脏	□	□	□
Bones/Joints/Muscles			
关节炎	□	□	□
肌肉疼痛	□	□	□
关节疼痛	□	□	□
Lymphatic/Hematologic			
贫血	□	□	□
出血问题	□	□	□
Allergic/Immunologic	□	□	□
Psychiatric	□	□	□
抑郁症	□	□	□

如果您有未列出的病症，请解释并列出药物:

_____

_____

Doctor's Signature(Reviewed)_____Date_____ **Patient's** Signature(Reviewed)_____Date_____
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