Cynthia Broady, Optometry - Patient History Questionnaire ***Today's Date:_____***

Full Name: _____ Birth Date: _____

Address: _____ Social Security #: _____

_____ Home Phone*: _____

Email Address: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Circle which number you would like us to use to communicate with you.

Or, tell us if you would rather we communicate with you via postal service or email.

Employer: _____ Driver's License: _____

Medical Insurance: _____ Medical Doctor: _____

Vision Insurance: NONE / YES: If yes, which insurance? _____

Date of your last physical: _____ Date of last eye exam: _____

Responsible party if different from patient: _____ Relationship: _____

Payment is expected when services are rendered.

Race: ☐ Caucasian ☐ African-American ☐ Asian

☐ Hispanic ☐ Native Indian ☐ Native Hawaiian/Pacific Islander

OCULAR HISTORY

Do you wear glasses? ☐ Yes ☐ No If yes, how old are they? _____

Do you wear contact lenses ☐ Yes ☐ No If yes, what type: (soft, hard): _____

How many days a week and hours a day do you wear your contacts?: _____

How long have your contact lenses been on today?_____ How often do you replace them? _____

What other services would you like to be evaluated for today ?:

- ○ Refractive surgery (lasik)
- ○ Computer glasses
- ○ Reading glasses
- ○ Contact lenses
- ○ Sunglasses
- ○ Golfing glasses

Have you had any eye surgeries? ☐ Cataract ☐ Refractive/Lasik ☐ Retinal ☐ Other

Are you currently experiencing any of the following eye conditions?: Check the boxes that apply.

☐ Blurred vision ☐ Flashes or floaters ☐ Redness ☐ Tearing ☐ Dryness

☐ Burning ☐ Sandy/gritty feeling ☐ Itching ☐ Pain/Sore ☐ Discharge

☐ Loss of Vision ☐ Double Vision ☐ Tired Eyes ☐ Distorted vision ☐ Other_____

Have you been diagnosed with any of the following eye conditions? Check the box if "Yes".

☐ Cataracts ☐ Glaucoma ☐ Retinal Detachment/Disease

☐ Dry eyes ☐ Macular Degeneration ☐ Eye Injury

☐ Lazy Eye/ Amblyopia ☐ Crossed Eye ☐ Other

MEDICAL HISTORY

List any medications you are currently taking (including contraceptives and over the counter medications): □ None

_____

_____

Are you allergic to any medications: □ None If yes, please list _____

List all major surgeries or hospitalizations you have had: _____

_____

REVIEW OF SYSTEMS: Please check the box of any problem you have or have had:

Allergic/Immunologic □ All Normal
- □ Allergy/hay fever

Cardiovascular/Cardiac □ All Normal
- □ Arteriosclerosis
- □ Heart Disease
- □ High Blood Pressure
- □ High Cholesterol

Constitutional □ All Normal
- □ Fever
- □ Weight loss/gain

Ear, Nose, Mouth, Throat □ All Normal
- □ Sinus Congestion
- □ Dry Throat, mouth

Endocrine □ All Normal
- □ Diabetes
- □ Thyroid Disease
- □ Chronic Fatigue

Gastrointestinal □ All Normal
- □ Diarrhea/Constipation
- □ IBS/Chron's Disease
- □ Ulcer
- □ Reflux

Genitourinary □ All Normal
- □ Kidney Disease
- □ Ovarian/Uterine Cancer
- □ Prostate Cancer

Hematologic/Lymphatic □ All Normal
- □ Anemia or bleeding problems
- □ Breast Cancer

Integumentary (Skin) □ All Normal
- □ Cancer
- □ Rashes
- □ Easy bruising

Musculoskeletal □ All Normal
- □ Rheumatoid Arthritis
- □ Muscle Pain
- □ Joint Pain

Neurological □ All Normal
- □ Migraines
- □ Dizziness
- □ Seizures
- □ Stroke

Psychiatric □ All Normal
- □ Anxiety
- □ Depression
- □ Memory Loss
- □ Hallucinations

Respiratory □ All Normal
- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ Chronic Cough

If you checked any of the above boxes or have a condition not listed, please explain further:

_____

_____

Height: _____ Weight: _____

FAMILY HISTORY Please note any family member (parent, grandparent, sibling, children) for the following conditions and include maternal or paternal:

	Relation to You		Relation to You
Glaucoma	_____	Diabetes	_____
Cataract	_____	Cancer	_____
Macular Degeneration	_____	Heart Disease	_____
Retinal Detachment	_____	High Blood Pressure	_____
Blindness	_____	Kidney Disease	_____
Crossed Eyes	_____	Lupus/Arthritis	_____

SOCIAL HISTORY This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. If so, please check this box □

Do you drive? □ No □ Yes If yes, do you have visual difficulty when driving? □ No □ Yes

If yes, please describe: _____

Do you smoke? □ No □ Yes If yes, How much and for how long? _____

Do you drink alcohol? □ No □ Yes If yes, What and how much? _____

Do you use illegal drugs □ No □ Yes If yes, What and how much? _____

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis □ None

Signature: _____ Date: _____

Future Reviews:

Signature: _____ Date: _____

Signature: _____ Date: _____

I, _____, have read Cynthia Broady Optometry's "Notice of Privacy Practices".

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES AS OF OCTOBER 21ST, 2014

Cynthia Broady, O.D.
17300 E. 17th St. Suite M * Tustin, CA 92780
714-838-9664
714-838-6774 * staff@drbroady.com * Office contact: Carla Waylett

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSTO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us at (310)-568-0193. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to 1) Share information with your family, close friends, or others involved in your care 2) Share information in a disaster relief situation 3) Include your information in a hospital directory

> *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission: 1) Marketing purposes 2) Sale of your information 3) Fundraising - We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways. 1) Treat you. We can use your health information and share it with other professionals who are treating you. 2) Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. 3) Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**
Help with public health and safety issues. We can share health information about you for certain situations such as 1) Preventing disease 2) Helping with product recalls 3) Reporting adverse reactions to medications 4) Reporting suspected abuse, neglect, or domestic violence 5) Preventing or reducing a serious threat to anyone's health or safety
Do research. We can use or share your information for health research.
Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you: 1) For workers' compensation claims 2) For law enforcement purposes or with a law enforcement official 3) With health oversight agencies for activities authorized by law 4) For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

1) We are required by law to maintain the privacy and security of your protected health information. 2) We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3) We must follow the duties and privacy practices described in this notice and give you a copy of it. 4) We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. 5) For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. 6) Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new one in our office and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

RE: Release form

Dear Dr. _____:

I authorize you to release my records or a copy of my records to the following office as soon as possible:

Cynthia Broady, O.D.
Jennifer Jensen, O.D.
17300 E. 17th St. Suite M
Tustin, CA 92780
Phone: (714) 838-9664
Fax: (714) 838-6774

Thank you for your cooperation.

_____
Patient's signature

(Please print)

Patient's name_____
Address _____
_____
Telephone _____