

# David Kirschen, OD, PhD & Isabell Choi, OD

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The information in this confidential personal history form is critical to the evaluation of your vision

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_ Email address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_  
Emergency contact name \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_  
Social Security # \_\_\_\_/\_\_\_\_/\_\_\_\_ Person Responsible for account \_\_\_\_\_  
Insurance that covers vision care?  Yes  No  VSP  MES  Medicare Other \_\_\_\_\_  
Date of last eye exam \_\_\_\_\_ Have you ever had vision therapy?  Yes  No  
Have you ever worn glasses?  Yes  No Do you wear glasses now?  Yes  No  
If yes:  for distance only  for near only  wear them full time  for computer monitor  sports

**Health History:** Please check for whom the conditions that apply to you or run in your family and state the name of the condition.

Allergies	<input type="checkbox"/> Self <input type="checkbox"/> Family _____	Lazy eye	<input type="checkbox"/> Self <input type="checkbox"/> Family _____
Respiratory Disease	<input type="checkbox"/> Self <input type="checkbox"/> Family _____	Turned eye	<input type="checkbox"/> Self <input type="checkbox"/> Family _____
Cancer	<input type="checkbox"/> Self <input type="checkbox"/> Family _____	Color blind	<input type="checkbox"/> Self <input type="checkbox"/> Family _____
Diabetes	<input type="checkbox"/> Self <input type="checkbox"/> Family _____	Light sensitive	<input type="checkbox"/> Self <input type="checkbox"/> Family _____
Drug Sensitivity	<input type="checkbox"/> Self <input type="checkbox"/> Family _____	Eye strain	<input type="checkbox"/> Self <input type="checkbox"/> Family _____
Elevated Cholesterol	<input type="checkbox"/> Self <input type="checkbox"/> Family _____	Dry eyes	<input type="checkbox"/> Self <input type="checkbox"/> Family _____
Heart Problem	<input type="checkbox"/> Self <input type="checkbox"/> Family _____	Floaters/spots	<input type="checkbox"/> Self <input type="checkbox"/> Family _____
High blood pressure	<input type="checkbox"/> Self <input type="checkbox"/> Family _____	Flashing lights	<input type="checkbox"/> Self <input type="checkbox"/> Family _____
Thyroid	<input type="checkbox"/> Self <input type="checkbox"/> Family _____	Retinal detachment	<input type="checkbox"/> Self <input type="checkbox"/> Family _____
Migraine of headaches	<input type="checkbox"/> Self <input type="checkbox"/> Family _____	Blindness	<input type="checkbox"/> Self <input type="checkbox"/> Family _____
Head trauma	<input type="checkbox"/> Self <input type="checkbox"/> Family _____	Cataracts	<input type="checkbox"/> Self <input type="checkbox"/> Family _____
Ear/Nose/Throat	<input type="checkbox"/> Self <input type="checkbox"/> Family _____	Glaucoma	<input type="checkbox"/> Self <input type="checkbox"/> Family _____
Gastrointestinal	<input type="checkbox"/> Self <input type="checkbox"/> Family _____	Eye surgery or injury	<input type="checkbox"/> Self <input type="checkbox"/> Family _____
Joints/Bones/Muscles	<input type="checkbox"/> Self <input type="checkbox"/> Family _____		
Lymphatic/Hematologic	<input type="checkbox"/> Self <input type="checkbox"/> Family _____		

Are you currently under a physician's care?  No  Yes Dr's name \_\_\_\_\_

Are you regularly taking medications?  No  Yes Date of last physical \_\_\_\_\_

Current medications \_\_\_\_\_

For what conditions? 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_

How is your general health? (Check one)  Excellent  Good  Fair  Poor

**SOCIAL HISTORY** This information is kept strictly confidential.

Do you use tobacco products?  Yes  No If yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol?  No  Yes If yes, type/amount/how long: \_\_\_\_\_

Do you use illegal drugs?  No  Yes If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

**VERY IMPORTANT! New Patients: WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?**

Name of friend or relative \_\_\_\_\_

If not referred, how did you choose our office for your visual needs? Please check appropriate answer:

Relative  Another doctor  Yellow Pages  Friend  Insurance list  Website

Saw sign/building  Other \_\_\_\_\_

**CONTACT LENSES:**

Do you wear contact lenses at this time? Yes No What type? \_\_\_\_\_  
Have you had problems wearing contacts? Yes No Describe \_\_\_\_\_  
Have you been told you cannot wear them? Yes No Reason \_\_\_\_\_  
Are you interested in trying contacts? Yes No

**OCCUPATION: What kind of work do you do?** \_\_\_\_\_

**What activities do you do at work? (Check all that apply)** driving typing data entry computers  
accounting writing/editing using spreadsheets loading deliveries sales inspecting  
Other activities: \_\_\_\_\_

**Do you use a computer on the job?** Yes No \_\_\_\_\_ # hours daily  
**Do you use a computer at home?** Yes No \_\_\_\_\_ # hours daily  
What lenses do you wear? None glasses bifocals progressive contacts  
When on the computer, do your eyes get: red dry ache sore  
Do you feel pain or discomfort in your: neck back shoulder  
Do letters ever seem to "swim"? Yes No  
Does office lighting ever bother you? Yes No  
Do reflections and glare bother you? Yes No  
Is it hard to proofread or find errors? Yes No

**Do you experience any of the following discomforts at work or a home? (Check all that apply)**

Headaches Letters blur as you read Occasionally see double  
Eyestrain Eyes red or watery Pulling sensation near eyes  
Get sleepy Lose place often  
Do you avoid certain tasks? Yes No What tasks? \_\_\_\_\_  
Does it take more and more effort to see clearly as the day wears on? Yes No  
Do you avoid reading after work, but read on weekends? Yes No How long can you read? \_\_\_\_\_  
Do you "hunch" closer to your work as the day wears on? Yes No  
Do street signs ever seem blurred as you drive home from work? Yes No  
Is it ever difficult to bring print or objects to clear focus? Yes No When? \_\_\_\_\_

**RECREATION AND LEISURE:**

**In what recreational activities do you participate? (Check all the apply)**

read racquetball tennis golf baseball basketball swim camp sew play cards flying  
video games musical instrument  
Other recreational activities \_\_\_\_\_

Do you wear any special or protective eyewear for your sport? Yes No  
Does your vision or do your lenses interfere with any activity? Yes No

**What are you doing to protect your eyes from ultraviolet exposure?** \_\_\_\_\_

**Do you currently wear glasses that have an anti-reflective coating?** \_\_\_\_\_

**Television:** is viewing ever uncomfortable? Please describe your discomfort:  
\_\_\_\_\_

Do you recline while watching TV? Yes No  
Do your current glasses work for TV? Yes No

Payment terms: We are happy to assist you in filing your insurance claim. If your insurance does not pay the anticipated amount, or your insurance pays you directly, we ask that you pay the balance. Office policy calls for payment at the time of service. We accept cash, personal checks, Visa, and Master Card. I have read and agree to all the provisions of the payment terms.

**ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I received a copy of Drs. David Kirschen and Isabell Choi 's Notice of Privacy Practices

Patient Name \_\_\_\_\_ Legal Guardian \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_