KAESTNER AESTHETIC EYE CENTER
477 N. El Camino Real, C-308
Encinitas, CA 92024
(760) 942-9225 fax (760) 942-9343

Joan H. Kaestner, MD

Jeanne W. Louie, OD

MEDICAL HISTORY QUESTIONNAIRE

Name________________________________ Date________________

Date of Birth ________________ Date of Last Eye Exam ________________

List any medications you currently take (prescription & over-the-counter): ________________

____

____

Do you have allergies to any medications? ☐ YES ☐ NO
If YES, list the medications: ________________

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.): ________________

____

____

Do you currently have any problems in the following areas? If YES, please provide information.

	YES	NO	EXPLANATION OF PROBLEM
EYES			
Glaucoma			
Macular Degeneration/Disease			
Cataract			
Retinal Disease			
Corneal Disease			
Uveitis/Iritis			
Loss of Vision			
Blurred Vision			
Fluctuating Vision			
Distorted Vision/Haloes			
Loss of Side Vision			
Poor Night Vision			
Double Vision			
Dryness			
Mucus Discharge			
Redness			
Sandy or Gritty Feeling			
Itching			
Burning			
Watering			
Glare/Light Sensitivity			
Eye Pain			
Infection of eye or lid			
Tired Eyes			
Crossed eyes/lazy eye			
Floaters			
Flashes of Light			
Injury			
Surgery			
Other			
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss/gain			
Other			
EARS, NOSE, THROAT			
Sinus Infection			
Ear Infection			
Chronic Cough			
Dry Mouth			
Other			
CARDIOVASCULAR			
Hypertension			
High Cholesterol			
Heart Attack			
Stroke			
Other			
RESPIRATORY			
Chronic Obstructive Pulmonary Disease			

	YES	NO	EXPLANATION OF PROBLEM
Emphysema			
Asthma			
Other			
GASTROINTESTINAL			
Stomach Ulcers			
Intestinal Disease			
Other			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS			
Osteoarthritis			
Rheumatoid Arthritis			
Other			
SKIN			
Acne			
Warts			
Psoriasis			
Roseacea			
NEUROLOGICAL			
Multiple Sclerosis			
Bell's Palsy			
Other			
PSYCHIATRIC			
Anxiety			
Depression			
Bipolar			
Other			
ENDOCRINE			
Diabetes Mellitus			
Hypothyroid			
Hyperthyroid			
Other			
BLOOD/LYMPH			
Anemia			
Other			
ALLERGIC/IMMUNOLOGIC			
Seasonal Allergies/Hay Fever			
Environmental Allergies			
Lupus			
Sjogren's			
Other Autoimmune Disease			
CANCER			

FAMILY HISTORY	YES	NO	EXPLANATION OF PROBLEM
Blindness			
Glaucoma			
Macular Degeneration			
Heart Disease (Hypertension, High Cholesterol, Heart Attack, Stroke)			
Diabetes			
Cancer			
Kidney Disease			
Autoimmune Disease			
Thyroid Disease			
Other			

SOCIAL HISTORY:

Current Occupation: ______________________________ Hobbies/Interests: ______________________________

Do you drive? ☐ YES ☐ NO

Do you use a computer? ☐ YES ☐ NO If YES, how many hours per day? ____________________

Do you currently wear glasses? ☐ YES ☐ NO If YES, how long have you had your current prescription? __________

Do you have a back-up pair of glasses? ☐ YES ☐ NO

Do you have prescription sunglasses? ☐ YES ☐ NO

Do you currently wear contact lenses? ☐ YES ☐ NO

Are you interested in wearing contact lenses? ☐ YES ☐ NO

Are you interested in LASIK/PRK? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO If YES: occasional 1 per day 2-3/day 4+/day

Do you smoke? ☐ YES ☐ NO If YES: occasional ½ pack/day 1 pack/day 1+ pack/day

Have you ever had a blood transfusion? ☐ YES ☐ NO

Patient's Signature: ____ Date ____________________

Physician's Signature: ____ Date ____________________

History Reviewed by Physician. ☐ No Changes ☐ Additions as noted above

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(Please PRINT legibly and complete ALL BLANKS)

PATIENT INFORMATION

NAME	DATE	ACCT # (OFFICE USE ONLY)
ADDRESS	SEX AGE	BIRTHDATE
CITY STATE ZIP CODE		DRIVER'S LICENSE #
HOME PHONE NUMBER CELL PHONE NUMBER	E-MAIL ADDRESS	
EMPLOYER'S NAME ADDRESS	PHONE NUMBER	
MARITAL STATUS SPOUSE'S NAME	SPOUSE'S CELL/WORK PHONE #	
WHO REFERRED YOU?	CAN WE SEND YOU A REMINDER POSTCARD FOR NEXT YEAR'S EXAM? ☐ YES ☐ NO	

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	MEDICARE #	
ID NUMBER	GROUP NUMBER	EMPLOYER
POLICY HOLDER'S NAME	POLICY HOLDER'S SOCIAL SECURITY #	POLICY HOLDER'S DATE OF BIRTH
INSURANCE ADDRESS	CITY	STATE ZIP CODE
SECONDARY INSURANCE NAME	MEDICARE #	
ID NUMBER	GROUP NUMBER	EMPLOYER
POLICY HOLDER'S NAME	POLICY HOLDER'S SOCIAL SECURITY #	POLICY HOLDER'S DATE OF BIRTH
INSURANCE ADDRESS	CITY	STATE ZIP CODE

WHO MAY WE CONTACT IN CASE OF EMERGENCY?

Name	Relationship	Home Phone #	Cell Phone #

HEALTH INFORMATION

PERSONAL PHYSICIAN	ADDRESS	CITY	STATE	ZIP CODE
DAILY MEDICATIONS AND DOSAGE				
***LIST ALL DRUG ALLERGIES**	DO YOU HAVE AN ADVANCED DIRECTIVE FOR HEALTH CARE? YES NO			

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I authorize payment of medical benefits payable to the physician. A copy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or changes in any of the information provided on the patient information sheet.

Patient's Signature: | **Date:**