

MEDICAL HISTORY QUESTIONNAIRE- OFFICE OF DR. HOWARD J. KASS

All information is private and confidential and will not be released to anyone except by written authorization from you or your legal guardian.

Name: _____ Date of Birth: _____ Today's Date: _____
 Address: _____ City: _____ State: _____ Zip: _____ Social Security #: _____
 Telephone Home: _____ Telephone Work: _____ Telephone Cell: _____
 Occupation: _____ Email Address: _____ Marital Status: S D M W
 Insurance Carrier: _____ Insurance ID#: _____
 Subscriber Name: _____ Subscriber SS# _____ Subscriber DOB: _____
 Primary Care Physician: _____ Physician's Telephone : _____ Date of Last Eye Exam: _____

HAVE YOU SEEN DR.KASS BEFORE: (Y) (N)

SOCIAL HISTORY: This Information Is Kept Strictly Confidential

Do You Drive (Y) (N) Do You Use Tobacco (Y) (N) Do You Drink Alcohol (Y) (N) Do You Use Illegal Drugs (Y) (N)
 Have You Been Exposed To (Gonorrhea) (Hepatitis) (HIV) (Syphilis)

Review of Systems: Do you or have you had any problems listed below:

	NO	YES	?	
Constitutional				
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>		Any YES answers Kindly explain below:
Integumentary (skin)				_____
Neurological				_____
Headaches	<input type="checkbox"/>	<input type="checkbox"/>		
Seizures	<input type="checkbox"/>	<input type="checkbox"/>		
Eyes				
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>		_____
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>		_____
Distorted/Halos	<input type="checkbox"/>	<input type="checkbox"/>		_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>		_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>		_____
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>		_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>		_____
Sandy Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>		_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>		_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>		_____
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>		_____
Excessive Tearing	<input type="checkbox"/>	<input type="checkbox"/>		_____
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>		_____
Glare	<input type="checkbox"/>	<input type="checkbox"/>		_____
Chronic Eye Infections	<input type="checkbox"/>	<input type="checkbox"/>		_____
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>		_____
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>		_____
Endocrine				
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>		_____
Ear/Nose/Mouth Throat				
Allergies	<input type="checkbox"/>	<input type="checkbox"/>		Any additional information you would like to discuss with Dr. Kass
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>		_____
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>		_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>		_____
Respiratory				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		_____
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		_____
Gastro urinary				
Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>		_____
Cardio-Vascular				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		_____
Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>		_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		_____
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>		_____
Bones/Joints/Muscles/Hematologic				
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		_____
Muscle or Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>		_____
Anemia Bleeding	<input type="checkbox"/>	<input type="checkbox"/>		_____
Allergic/Psychiatric/Immunologic				

MEDICAL HISTORY: Dr. Kass Will Dilate Your Eyes Depending On Your Medical History And Need.

Do You Have Any Allergies: (Y) (N) Are You Pregnant: (Y) (N) Have You Had LASIK Surgery: (Y) (N)

Medication You are Taking: _____

Major Injuries Including Eye Injuries: _____

Do You Wear Contact Lenses: (Y) (N) How Old Are They: _____ (Soft) (Hard) (Bifocal)

Do you or any blood-related family member have or have had any of the following?

DISEASE	NO	YES	FAMILY-Relationship to You	DISEASE	NO	YES	FAMILY-Relationship to You
Contact Lens Problems				Blurred/ Double Vision			
Cataract				Sandy or Gritty Feeling			
Glaucoma				Redness			
Retinal Disorder				Foreign Body Sensation			
Macular Degeneration				Dry Eye			
High Blood Pressure				Light /Glare Problems			
Kidney Disease				Eye Pain			
Thyroid Disease				Chronic Eye Infections			
Cancer				Excessive Tearing			
Lupus				Flashes or Floaters			
Heart Disease				Tired Eyes			
High Cholesterol				Crosses Eyes			
Diabetes				Amblyopia/ Lazy Eye			
Headaches/ Migraines				Sinus Problems			
Seizures				Allergies or Hay Fever			
Vascular Disease				A Steroid Responder			
Rheumatoid Arthritis				Had Eye Surgery			
Psychiatric Disorders				Other			

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. Signature _____

I also authorize Dr. Howard J Kass to bill my insurance company for reimbursement for his professional services. By signing I indicate he has my permission to collect his fees directly from my Insurance carrier. I understand I am responsible for whatever my Insurance Company does not pay. This indicates a signature on file as well.

Signature on File _____ DOB _____

Any additional information you would like to discuss with Dr. Kass

EE CLE BIF CL TORIC CL EXTENDED CL MONO CL GP CL MEDICAL OTHER FEE