Medical History

Name _____ Age _____ Today's Date _____

Marital Status _____ Occupation _____

Primary Care Provider _____ Location _____

Have you ever had any of the following problems?

CANCER
- ☐ Breast
- ☐ Prostate
- ☐ Skin
- ☐ Other _____

CARDIO/VASCULAR
- ☐ Angina
- ☐ Bleeding Problems
- ☐ Blood Thinners
- ☐ Carotid Artery Disease
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Surgery
- ☐ High Blood Pressure / Low Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heartbeat
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ T.I.A.

ENDOCRINE
- ☐ Auto-immune Disorder _____
- ☐ Diabetic Non-insulin
- ☐ Diabetic Insulin
- ☐ Hypoglycemia
- ☐ Thyroid Hypo / Hyper

EYES
- ☐ Amblyopia / Lazy Eye
- ☐ Blindness
- ☐ Cataract
- ☐ Crossed Eyes
- ☐ Double Vision
- ☐ Eye trauma / injury
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Refractive Procedure
- ☐ Retinal Detachment

PULMONARY
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Environmental Allergies

OTHER
- ☐ Arthritis / Osteoporosis
- ☐ Alzheimer's
- ☐ Anxiety
- ☐ Claustrophobia
- ☐ Dementia
- ☐ Depression
- ☐ Hearing Aides / Deafness
- ☐ Hepatitis
- ☐ Hernia
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Parkinson's
- ☐ Phlebitis
- ☐ Seizures / Tremors
- ☐ Sexually Transmitted Diseases
- ☐ Ulcers
- ☐ Unintentional Weight Loss
- ☐ OTHER _____
- ☐ _____
- ☐ _____

Have you ever had any of the following surgeries?
- ☐ Cataract Surgery
- ☐ Corneal Transplant
- ☐ Retinal Repair
- ☐ Refractive Surgery
- ☐ Eye Muscle Surgery
- ☐ Eye Laser Procedure
- ☐ Eyelid Surgery
- ☐ Eye Injury / Trauma
- ☐ Artificial Joints
- ☐ Back
- ☐ Blood Transfusions
- ☐ Appendectomy
- ☐ Cancer _____
- ☐ Gallbladder Surgery
- ☐ Hernia
- ☐ Thyroid
- ☐ Heart Bypass
- ☐ Angioplasty
- ☐ Heart Valve
- ☐ Prostate / Hysterectomy
- ☐ OTHER _____
- ☐ _____
- ☐ _____
- ☐ _____

Is there a family history of any of the following?

	No	Yes	Relationship		No	Yes	Relationship		No	Yes	Relationship
Blindness	☐	☐	_____	Glaucoma	☐	☐	_____	Macular Degeneration	☐	☐	_____
Cataract	☐	☐	_____	Heart Disease	☐	☐	_____	Retinal Detachment	☐	☐	_____
Diabetes	☐	☐	_____	Lazy Eye	☐	☐	_____				

Do you smoke? ☐ Yes ☐ No How many per day? _____ For how many years? _____

Do you drink alcohol? ☐ Yes ☐ No How often? _____

(OVER)

DR. GERALD E. OLSON OPTOMETRIST & ASSOCIATES

YOUR EYES™ CLINICAL EVALUATION FORM

To evaluate your vision needs, we need to know a little more about you. Please fill in the blanks below.

Name _____ Date _____

Type of work _____

Favorite leisure activities _____

About how many hours per week do you spend:

At a computer _____

Outdoors _____

Driving/daytime _____

Driving/nightime _____

Playing Sports _____

Are your eyes sensitive to sunlight? yes ☐ no ☐

Rx		SPHERICAL	CYLINDRICAL	AXIS	PRISM	BASE
D.V.	O.D.					
	O.S.					
N.V.	O.D.					
	O.S.					

REMARKS _____ DATE: _____

(for office use only)

POLYCARBONATE

☐ AR (no reflections)

☐ AR with Transitions (variable tint/ no reflections)

HI-INDEX

☐ AR (no reflections)

☐ AR with Transitions (variable tint/ no reflections)

CR-39

☐ AR (no reflections)

☐ AR with Transitions (variable tint/ no reflections)

YOUR LIFESTYLE

(2nd pair special)

☐ Computer

☐ Polarized

Signature: _____

Medical History

Name _____ Age _____ Date _____

Do you have any special needs?

☐ Wheelchair? Are you able to transfer on your own to an exam chair? ☐ Yes ☐ No
☐ Walker
☐ Oxygen
☐ Hearing Aide(s)
☐ Deaf? Do you read lips or use Sign Language? ☐ Yes ☐ No
☐ OTHER: _____

Does anyone have medical power of attorney for you? _____
In case of an emergency, whom should we call?
Name _____ Relationship _____ Phone # _____

List all medications and/or foods you are ALLERGIC to:

_____ _____
_____ _____
_____ _____

LIST ALL MEDICATIONS (Prescription and Over the counter) you are currently taking:

NAME OF MEDICATION	DOSAGE	ADDED	DISCONTINUED

I authorize Dr. Gerald Olson to discuss my care with the following:

Name_____ Relationship _____

Name_____ Relationship _____

Patient signature _____ Date _____

Effective date of notice: April 14, 2003

NOTICE OF PRIVACY PRACTICES

Gerald E. Olson, O.D.
2001 Lincoln Way, White Oak, PA 15131
412-673-1243
412-673-1124 (fax)
olsonstaff@olsoneyecare.com
Contact: Carol Michnowicz

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO 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.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

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. Unless you tell us otherwise, we will mail you an appointment reminder , and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

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 notice in our office, have copies available in our office, and post it on our Web site.