MARIN OPTOMETRIC GROUP, INC

Darwin Tsang,OD | Tina Cheung,OD | Robert Levine,OD
1001 Grand Avenue, San Rafael, CA 94901
(T) 415.453.3812 | (F) 415.453.6712

**Contact Information**

Name (Last, First): _____
Date of Birth: _____
Social Security Number: _____ - _____ - _____
Address: _____
City: _____ State: ____ Zip: _____
Home phone_____
Cell phone _____
E-mail _____

Employer: _____
Occupation: _____

**Vision Insurance Information**

□ Vision Service Plan (VSP) □ None
□ EyeMed / Blueview Vision
□ Medical Eye Services (MES)
□ Medicare Part A

Name of Policy Holder: _____
Policy Holder's Date of Birth _____
Social Security Number: _____ - _____ - _____
Insurance ID # : _____

**Medical History Questionnaire**

Do you smoke? □ Yes □ No
Amount and how long? _____
Do you consume alcohol? □ Yes □ No
Amount and how long? _____
Date of Last Physical Exam: _____
Name of Provider: _____
Date of Last Eye Exam:_____
Name of Eye Doctor: _____

List all medications you are currently taking:

Do you have any allergies to medications? □ Yes □ No
If yes, please indicate which medications:

Do you currently wear glasses? □ Yes □ No
Do you wear contact lenses? □ Yes □ No
What brand of contact lenses?

Are they comfortable? □ Yes □ No

**Review of Systems, please check all that apply to you:**

**EYES**

□ Vision Loss □ Itching □ Eye Pain / Soreness
□ Blurry Vision □ Gritty Feeling □ Mucous Discharge
□ Sties □ Burning □ Excess Watering
□ Dryness □ Light Sensitivity □ Retinal Detachment
□ Redness □ Glaucoma □ Diabetic Retinopathy
□ Flashes □ Floating Spots □ Chronic Infection
□ Tired Eyes □ Cataracts □ Macular Degeneration
□ Distorted Vision

**GASTROINTESTINAL**

□ Colitis □ Ulcers □ Crohn's Disease
□ Diarrhea □ Constipation

**CONSTITUTIONAL**

□ Fever □ Fatigue □ Weight Loss / Gain
□ Trauma

**INTEGUMENTARY (SKIN)**

□ Eczema □ Rosacea □ Psoriasis

**NEUROLOGIC**

□ Headaches □ Seizures □ Multiple Sclerosis
□ Migraines

**ENDOCRINE**

□ Diabetes Type 1 or 2 □ Hormonal Dysfunction
□ Thyroid Dysfunction

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**RESPIRATORY**

□ Asthma □ Bronchitis □ Emphysema

**CARDIOVASCULAR**

□Hypertension □ Heart Disease □ Hypercholesterolemia

**EARS / NOSE / THROAT**

□ Allergies □ Runny Nose □ Sinus Congestion

□ Dry Throat □ Chronic Cough □ Post Nasal Drip

□ Dry Mouth

**ALLERGIC / IMMUNE**

□ Lupus □ Drug Allergies □ Seasonal Allergies

□ Arthritis

**LYMPHATIC / HEMATOLOGIC**

□ Anemia □ Leukemia □ Bleeding Problems

**MUSCULOSKELETAL**

□ Fibromyalgia □ Osteoarthritis □ Muscular Dystrophy

□ Ankylosing Spondylitis

**GENITOURINARY**

□ STD's □ Bladder Problems □ Kidney Problems

**Family Medical History**
Please check the box if someone has or has previously had a condition. If you check a box, please indicate in the line who?

□ Blindness _____ □ Diabetes _____

□ Lazy Eye _____ □ Heart Disease _____

□ Macular Disease _____ □ Hypertension _____

□ Glaucoma _____ □ Thyroid Disease _____

□ Retinal Disease _____ □ Other _____

**How did you hear about us!**
□ Yelp
□ Facebook
□ Instagram
□ Google
□ Friend/Family recommendation
Who? So we know who to thank_____
□ Other: _____

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Marin Optometric Group, Inc., make every effort to inform you of your rights related to your personal health information.

By my signing below, I acknowledge that **(PLEASE CHECK ONLY ONE)**:

□ I have read or had explained to me Marin Optometric Group, Inc. Notice of Privacy Practices and agree to continue my care with Marin Optometric Group, Inc. under said terms.

□ *The Notice of Privacy Practice could not be read due to the emergent nature of the care for another reason.*

**I have read and understand this form. I am signing it voluntarily.**

Patient Signature: _____
Date: _____

If you are signing as a personal representative of the patient, please indicate your relationship Representative:
_____
Relationship to Patient:
_____