Dr. William C. Smith II, OD, P.C.

119 South Academy Street
Murfreesboro, TN 37130
Phone 615-893-1913
Fax 615-893-1917

Medical History Questionnaire

Family History

Please check "**YES**" if any family members have the following diseases/conditions:
If "**Yes**" mark "**FM**" with: mother-**M**, father-**F,** sister-**S**, brother-**B** grandparent-**GP**

	Yes	FM		Yes	FM		Yes	FM
Arthritis	___	___	Type 1 Diabetes	___	___	High Blood Pressure	___	___
Blindness	___	___	Type 2 Diabetes	___	___	Heart Disease	___	___
Cancer	___	___	Glaucoma	___	___	Macular Degeneration	___	___
Cataracts	___	___	Hypothyroid	___	___	Retinal Disease	___	___
Crossed Eyes	___	___	Hyperthyroid	___	___			

Social History

	Yes	No
Alcohol	___	___
Quantity	_____	
Tobacco	___	___
Type & Quantity	_____	

Review of Systems

Please check the symptoms and/or conditions below that may apply to you.

EYES

	Yes	No		Yes	No		Yes	No
Blurred Vision	___	___	Flashers/Floaters	___	___	Glare/Light Sensitive	___	___
Burning	___	___	Foreign Body	___	___	Eye or Lid Infection	___	___
Cataracts	___	___	Glaucoma	___	___	Mucous Discharge	___	___
Crossed Eyes	___	___	Itching	___	___	Sandy/Gritty Feeling	___	___
Distorted Vision (Halos)	___	___	Lazy Eye	___	___			
Double Vision	___	___	Redness	___	___			
Dryness	___	___	Loss of Vision	___	___			
Excess Tearing / Watering	___	___	Retinal Disease	___	___			
Eye Pain or Soreness	___	___	Styes or Chalazion	___	___			

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BONE/ JOINT/ MUSCLE

	Yes	No
Muscular Dystrophy	___	___
Fibromyalgia	___	___
Osteoporosis	___	___
Osteoarthritis	___	___
Arthritis	___	___
Gout	___	___
Ankylosing Spondylitis	___	___

EAR /NOSE/ THROAT

	Yes	No
Sinus Congestion	___	___
Runny Nose	___	___
Hearing Loss	___	___
Laryngitis	___	___
Chronic Cough	___	___
Dry Mouth/Throat	___	___

CANCER

	Yes	No
Breast	___	___
Bone	___	___
Lung	___	___
Skin	___	___
Prostate	___	___

VASCULAR

	Yes	No
Congestive Heart Failure	___	___
High Blood Pressure	___	___
Type 1 Diabetes	___	___
Type 2 Diabetes	___	___
Vascular Disease	___	___
Stroke	___	___
Heart Disease	___	___

NEUROLOGIC

	Yes	No
Multiple Sclerosis	___	___
Cerebral Palsy	___	___
Headaches	___	___
Migraines	___	___
Epilepsy/Seizures	___	___
Tumor	___	___
Bells Palsy	___	___

RESPIRATORY

	Yes	No
Chronic Bronchitis	___	___
Emphysema	___	___
Sleep Apnea	___	___
Tuberculosis	___	___
COPD	___	___
Asthma	___	___

BLOOD ISSUES/DISORDERS

	Yes	No
Bleeding disorders	___	___
Liver Disease	___	___
HIV Positive	___	___
Hepatitis	___	___
Anemia	___	___
AIDS	___	___
High Cholesterol	___	___

PSYCHIATRIC

	Yes	No
High Anxiety	___	___
Depression	___	___
Bi-polar	___	___
ADHD	___	___
ADD	___	___
Other	_____	

REPRODUCTIVE

	Yes	No
Currently Pregnant	___	___
Currently Nursing	___	___

GASTROINTESTINAL

	Yes	No
Crohn's Disease	___	___
Celiac Disease	___	___
Acid Reflux	___	___
Colitis	___	___
Ulcers	___	___

INTEGUMENTARY

	Yes	No
Cold Sores	___	___
Shingles	___	___
Psoriasis	___	___
Rosacea	___	___
Eczema	___	___

GENITOURINARY

	Yes	No
Kidney Disease	___	___
Prostate Disease	___	___

CONSTITUTIONAL

	Yes	No
Developmental Disabilities	___	___
Sudden Weight Loss/Gain	___	___
Fatigue Syndrome	___	___
Fever	___	___

ENDOCRINE

	Yes	No
Hormonal Dysfunction	___	___
Hypo-Thyroid	___	___
Hyper-Thyroid	___	___
Graves Disease	___	___

ALLERGY/IMMUNE

	Yes	No
Environmental Allergies	___	___
Drug Allergies	___	___

	Yes	No
Sjogren's Syndrome	___	___
Lupus	___	___

	Yes	No
Hay Fever	___	___

- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:

    - was not created by us, unless the person that created the information is no longer available to make the amendment,
    - is not part of the health information kept by or for us,
    - is not part of the information you would be permitted to inspect or copy, or
    - is accurate and complete.

- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Dr William C Smith OD
615-893-1913

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: September 23, 2013

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. William C Smith O.D., Notice of Privacy Practices.

Date _____ Patient name_____ Signature _____