Ferguson Optical Patient History Questionnaire

General Patient Information

Patient Name: (Mr. / Mrs. / Ms.)________________________________ Date of Birth: ______________

Street: ____ Home Phone: (_______)______________

City: ______________________ State: _________ Zip: _________ Cell Phone: (_______)______________

Social Security Number: __________________________ E-Mail: ______________________

Occupation: ____________ Employer: __________________ Work Phone: (_______)______________

Eye History

Approx. Date of Last Eye Exam: ______________ Examined by ______________________________

Are you currently having eye or vision problems? ☐ Yes ☐ No If yes, please explain. ______________________

Do you wear glasses? ☐ Yes ☐ No How old? _______ Are they bifocals? ☐ Yes ☐ No Are they for ☐ Full time ☐ Distance ☐ Near

Do you wear contact lenses? ☐ Yes ☐ No Type/Brand______________ Hours/Day_____ Are you interested in contacts? ☐ Yes ☐ No

Medical History

Please list any medications **YOU** are now taking (including hormones, birth control, aspirin or other anti-inflammatories, eye drops, home remedies, and over-the-counter medications): ____

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PLEASE CHECK ALL THAT APPLY

FAMILY MEDICAL HISTORY

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Blindness
- ☐ Cataracts
- ☐ Eye Disease
- ☐ Glaucoma
- ☐ Lazy Eye
- ☐ Color Blindness
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Other—Explain Below

PATIENT'S MEDICAL HISTORY

- ☐ Head Injury
- ☐ Skin Condition
- ☐ Drug Allergies
- ☐ Bleeding Disorder
- ☐ High Blood Pressure
- ☐ Heart Problems
- ☐ Gastrointestinal
- ☐ Ear/Nose/Throat
- ☐ Cardiovascular
- ☐ Musculoskeletal
- ☐ Dental Problems
- ☐ Developmental
- ☐ Headaches
- ☐ Diabetes
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Emphysema
- ☐ HIV
- ☐ Migraines
- ☐ Nervous
- ☐ Mental
- ☐ Genitourinary
- ☐ NO MEDICAL CONDITIONS
- ☐ Sinus Problems
- ☐ Surgical Operations
- ☐ Thyroid Disorder
- ☐ Drug Use
- ☐ Alcohol Use
- ☐ Tobacco Use
- ☐ Endocrine
- ☐ Pre/Postnatal Problems
- ☐ Allergic/Immunologic
- ☐ Pregnant/Nursing
- ☐ Cholesterol

PATIENT'S EYE HISTORY

- ☐ Eye Injury
- ☐ Flashes/Floaters
- ☐ Double Vision
- ☐ Eye Surgery
- ☐ Loss of Vision
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Dry Eye
- ☐ Blurred Vision
- ☐ Lazy Eye
- ☐ NONE

Reviewed by Dr. ____________

Insurance Information

Policy Holder Name: ______________________, Birthdate: ____________, Social Security Number: ____________

Medical Insurance: ______________________________ Member Number: ______________________

Vision Insurance Carrier: __________________________ Member Number: ______________________

I certify that I have insurance coverage under the insurance plan indicated above. I will assign directly to Ferguson Optical all insurance benefits payable for services rendered. I understand that I am ultimately financially responsible for all charges. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance submissions. The HIPAA Policy for the office is available upon request during my office visit. I agree to abide by all office policies regarding glasses and contact lens orders and follow-up appointments. I understand that violation of these policies may result in additional fees, loss of deposits paid, or the voiding of any service contracts. PAYMENT IS DUE AT THE TIME OF SERVICE.

Signature of Patient (or responsible party): ______________________________ Date: ______________