Patient Information Questionnaire

First Name _____ MI_____ Last Name_____

Address _____ City _____ State _____ Zip_____

Telephone: Cell_____ Work _____ Home _____

Social Security or Unique ID# _____ Date of Birth _____
Employer_____ Occupation _____
Emergency Contact _____ Number _____
Date of Last Eye Exam _____ Reason for today's visit _____

Medical History

How is your general health? _____
Do you have any problems with or take medication for any of these systems? (Circle Yes or No)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____
Diabetes Yes/No Type _____ Date of diagnosis _____
Allergies to medication Yes/No Which? _____ Reactions? _____
Other health problems? _____
Current medications? _____
Have you had any surgeries? Yes/No What kind? _____ When? _____
Do you use Cigarettes, Tobacco, Alcohol, Other substances? (Circle) Explain_____
Name of family doctor _____ Date of last visit _____
Date your blood pressure was last checked? _____What was it? _____

Family History- Do you or anyone in your family have:

High blood pressure	Yes/No	Relation_____	Macular degeneration	Yes/No	Relation_____
Diabetes	Yes/No	Relation_____	Retinal detachment	Yes/No	Relation_____
Glaucoma	Yes/No	Relation_____	Cataracts	Yes/No	Relation_____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? _____
Have you had any eye surgeries? Yes/No Type_____
Have you had an eye injuries? Yes/No Kind_____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contacts?	Yes/No	Type_____	

Do you have any special job related vision needs? Yes/No Type_____
Additional information_____

Billing Information

Vision Insurance (Circle) VSP Davis Eye Med Other: _____
Primary Insured's Name _____ DOB: _____
SSN or Unique ID #_____
Medical Insurance _____
Medicare & Supplemental Insurance: _____ **(we'll copy the cards)**
Medicare #: _____ Supplemental #: _____
Who may we thank for the referral? _____

I authorize the release of medical information necessary to process any claim for payment and authorize payment to Dr. Vanessa Ferrucci. I agree that I am responsible for any co-pays, deductibles and amounts not covered by my insurance.

Signed: _____ Date: _____