PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Date: Patient E-mail:

Last Name _____ First Name _____ MI ____ Marital Status S M D WID

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Occupation _____ Employer _____

Date of Last Exam (*if not done at this office*) _____ Exam done by Dr. _____

Responsible Party for Payment _____

PRIMARY VISION INS _____ **SECONDARY VISION INS** _____

PRIMARY MEDICAL INS _____ **SECONDARY MEDICAL INS** _____

Primary INS Holder Last 4 Digits of SS# _____ **Patient's Last 4 Digits of SS#** _____

Medical Information - Review of Systems

What is your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Do you have problems with any of the following?

Cardiovascular ..... ☐ Yes ☐ No

Eyes (burn / itch) ..... ☐ Yes ☐ No

Endocrine (glands) ..... ☐ Yes ☐ No

Allergic / Immunologic ..... ☐ Yes ☐ No

Respiratory ..... ☐ Yes ☐ No

Do you smoke? ..... ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No Type _____ Date of Diagnosis _____

CURRENT MEDICATIONS _____

Allergies to Medications: ☐ Yes ☐ No Which? _____

Reaction(s)? _____

Other Health Problems _____

NAME and **CITY** of Family Doctor _____

Personal Eye Information

Have you had any eye operations? ☐ Yes ☐ No Type _____ Date _____

Have you had an eye injury? ☐ Yes ☐ No Kind _____ Date _____

Retinal Detachments? ☐ Yes ☐ No Blurred Vision? ☐ Yes ☐ No

Do you wear Glasses? ☐ Yes ☐ No Contact Lenses? ☐ Yes ☐ No Brand _____

Additional Information _____

Who may we thank for referring you to our office? _____

Doctor Use Only

Reviewed by _____ ❑ No Changes Date _____

Reviewed by _____ ❑ No Changes Date _____

Reviewed by _____ ❑ No Changes Date _____

SCOTT M. HUSSING, O.D.
NIKOLAUS W. FATH, O.D.

646 Portage Trail, Suite A
Cuyahoga Falls, Ohio 44221
Phone: 330-929-9941
Fax: 330-929-3926

307 W. Main Street
Kent, Ohio 44240
Phone: 330-673-7538
Fax: 330-673-0647

PATIENT CONSENT FORM

Your privacy, including the confidentiality of your health information, is very important to us. Additionally, federal law prohibits the unauthorized release of your protected health information except as allowed for treatment, payment, or health care operations.

To protect your personal health information, our office has a Notice of Privacy Practices that provides information about how we may use and disclose your protected health information. You have the right to review the Notice of Privacy Practices before signing this consent form. The terms of our Notice of Privacy Practices may change. If we change our Notice, you may obtain a revised copy by calling our office.

You also have the right to request that we restrict how your protected health information can be used or disclosed for treatment, payment, or health care operations.

By signing this form, you have agreed to our use and disclosure of your protected health information under the guidelines set up for federal regulations. You may revoke your consent, in writing, at any time, except to the extent that we have already acted in reliance upon your consent as shown by your signature below.

Print Name **(Patient's)** _____

Signature _____

(Parent's signature is patient is a minor)

Date _____