**Dennis L. Olson, O.D.**

Developmental Optometrist

In order for us to gain a more comprehensive awareness of your general and visual health history and to satisfy certain insurance company requirements please complete this information to the best of your ability.

## PATIENT HISTORY QUESTIONNAIRE

Last name_____ First name_____ MI_____

Address_____ Zip_____

Telephone (H)_____ (W) _____

SSN_____-_____-_____ Date of birth_____

Occupation_____

Employer_____

Emergency contact / Telephone no._____

E-mail _____

## MEDICAL INFORMATION

How is your general health?_____

Do you have problems with any of these systems? (*please circle all that apply*)

| | | | | | |
|---|---|---|---|---|---|
| Gastrointestinal | Y / N | Nervous | Y / N | Eyes | Y / N |
| Ears/Nose/Throat | Y / N | Genitourinary | Y / N | Mental | Y / N |
| Cardiovascular | Y / N | Musculoskeletal | Y / N | Endocrine (glands) | Y / N |
| Respiratory | Y / N | Integumentary (skin) | Y / N | Blood/lymph | Y / N |
| | | | | Allergic/Immunologic | Y / N |

Please explain_____

**Please answer all that apply to you:**

Diabetes Y / N Type_____ Date of diagnosis_____

Allergies Y / N Allergic to what?_____ What happens?_____

**(please complete back side)**

Headaches Y / N Describe_____

Current medication(s)_____

Are you taking any vitamins? _____

Have you had any operations? Y / N Kind?_____ When?_____

Do you use cigarettes/tobacco?_____ Alcohol?_____ Other substance(s)?_____

Name of family doctor_____ Date of last visit?_____

Date of last tetanus shot?_____

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## IS THERE ANY FAMILY HISTORY OF THE FOLLOWING

(Parents, Grandparents, Aunts, Uncles, Sisters, Brothers)

High blood pressure Y/N Relation_____ Macular degeneration Y/N Relation_____

Diabetes Y / N Relation_____ Retinal detachment Y / N Relation_____

Glaucoma Y / N Relation_____ Cataracts Y / N Relation_____

Other eye condition(s) Y / N What kind?_____

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## PERSONAL EYE INFORMATION

Date of last eye exam_____ Dilated? Y / N

Have you had any eye operations? Y / N Type_____ Date_____

Have you had any eye injuries? Y / N Kind_____ Date_____

Do you have glaucoma? Y / N Cataracts? Y / N Dry eyes? Y / N Blurred vision? Y / N

Other eye problems? Y / N What kind?_____

Do you wear glasses? Y / N Contact lenses? Y / N Type_____

Additional information, questions or concerns_____

_____

Whom may we thank for referring you?_____

Doctor's initials_____

### Acknowledgement of Receipt

I acknowledge that I received a copy of Dennis L. Olson O.D.'s Notice of Privacy Practices.

Patient Name_____

Signature_____ Date_____