Patient Information

Last Name: _____

First Name: _____

Preferred Name: _____

Date of Birth: _____

SSN: _____ Gender: Male Female

Street Address: _____

City: _____ Zip Code: _____

Cell Phone: _____

Home Phone: _____

Email: _____

Employer (or School): _____

Occupation (or grade): _____

Physician: _____

Pharmacy / Location: _____

Insurance Information (Vision):

Insurance Carrier: _____

Policy Number: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____

Insurance Information (Medical):

Insurance Carrier: _____

Policy Number: _____

Policy Holder's Name: _____

Policy Holder's DOB: _____

Emergency Contact:

Name: _____ Phone: _____

How did you hear about us? _____

Allergies:

___ Penicillins ___ Sulfa ___ Latex ___ Seasonal

___ Anesthetic Drugs ___ Other: _____

Review of Systems

OLSON EYE CARE

Please check all that apply:

Constitution
- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome

ENT
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis

Neurological
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke

Psychological
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety
- ☐ Bipolar Disorder

Cardiovascular
- ☐ Hypertension
- ☐ Stroke
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea

☐ **None of the Above**

Gastrointestinal
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease

Genitourinary
- ☐ Kidney Disease
- ☐ Prostate Disease / Cancer
- ☐ Pregnant / Nursing

Musculoskeletal
- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoporosis
- ☐ Gout

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex / Cold Sores
- ☐ Herpes Zoster / Shingles

Endocrine
- ☐ Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction

Hematologic
- ☐ Anemia
- ☐ Ulcer
- ☐ Elevated Cholesterol

Immunologic
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome

Medications:

_____

_____

_____

X_____ _____

Patient Signature / Parent if minor Date