DR. ROBERT A. LARSON
OPTOMETRIST

PATIENT HISTORY QUESTIONNAIRE

Today's Date _____

Last Name_____ First Name_____ MI____

Address_____City_____ State_____Zip_____

Work Phone_____Cell Phone_____

Email_____ SS# (last 4 digits)_____

Date of Birth_____Occupation_____Employer_____

Emergency Contact Name_____Phone Number_____

Date of Last Eye Exam_____Dilated? Yes/No Referred By_____

Primary Vision Coverage_____Secondary Coverage_____

MEDICAL INFORMATION

What is your general health?_____ High Blood Pressure? Yes/No

Diabetes? Yes/No Type?_____ Date of Diagnosis_____

Allergies to Medication? Yes/No Which?_____Reactions_____

Other health problems_____

Current medication(s)_____

Name of Family Doctor_____Date of Last Visit_____

FAMILY HISTORY

High Blood Pressure? Yes/No Relation_____ Diabetes? Yes/No Relation_____
Macular Degeneration? Yes/No Relation_____ Glaucoma? Yes/No Relation_____
Retinal Detachment? 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 operations? Yes/No Type_____Date_____
Have you had an eye injury? 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 Contact lenses? Yes/No Type_____

Additional Information_____

DOCTOR USE ONLY

Reviewed By_____ No changes _____ Date_____