Northwest Eye Associates

Name_____ **Date of Birth**_____ **Date**_____

Reason for today's visit: _____

Patient Medical History

Name of Family Physician_____ City/State_____ Date of Last Exam_____

Current Medications: (include eye drops, over the counter medications, oral contraceptives, vitamins, herbs, and prescriptions)

_____

_____

_____

Allergic to Medications: ❑ Yes ❑ No _____

_____

Social History

Use of Alcohol: ❑ None ❑ Social use only ❑ 1-2 drinks daily ❑ Above average use ❑ Alcohol Dependence

Use of Tobacco: ❑ Never ❑ Former Smoker ❑ Light Smoker ❑ Average Smoker ❑ Heavy Smoker

Use of Other Substances: ❑ None ❑ Type & frequency_____

Contact Lens History

Do you currently wear contact lenses? ❑ Y ❑ N Hours per day: _____ Days per week:_____

Brand or prescription you are currently wearing? _____

Do you have a current pair of glasses in addition to your contacts? ❑ Y ❑ N

Glasses History

Do you currently wear glasses? ❑ Y ❑ N (Please Circle) Part-time Full-time Distance Near

Glasses being worn now: (Please Circle) Single Vision Bifocals Progressive Trifocals

Do you wear sunglasses: ❑Y ❑ N Are your sunglasses your most recent prescription? ❑ Y ❑ N

Current Eye Symptoms/Conditions:

Do you or have you ever experienced the following? ❑ Yes ❑ No (If yes, please indicate below.)					
	Headaches		Excess Tearing/Watering		Blurred Distance Vision
	Glare/Light Sensitivity		Eye Pain/Soreness		Blurred Near Vision
	Tired Eyes		Sandy/Gritty Feeling		Fluctuating Vision
	Amblyopia/Lazy Eye		Foreign Body Sensation		Glaucoma
	Burning		Mucous Discharge		Cataracts
	Dryness		Distorted Vision/Halos		Retinal Detachment
	Itching		Loss of Side Vision		Macular Degeneration
	Redness		Floaters/Spots		

PLEASE FILL OUT BOTH SIDES OF THIS FORM

Personal Medical History:

Have you ever been diagnosed or treated for the following? ❑ Yes ❑ No (If yes, please indicate below.)					
Cardiovascular		**Integumentary**		**Musculoskeletal**	
	Congestive Heart Failure		Acne Rosacea		Arthritis
	Elevated Cholesterol		Dry Mouth / Swallowing Problems		Gout
	Heart Disease		Psoriasis		Rheumatoid Arthritis
	High Blood Pressure			**Neurological**	
	Stroke / TIA	**Head/ENT/Dental**			Bell's Palsy
			Allergies		Brain Tumor
Endocrine			Dizziness		Multiple Sclerosis
	Adrenal Disorder		Headaches/Migraines		Parkinson's Disease
	Diabetes		Sinusitis		Seizures
	Thyroid (High or Low)				
		Hematologic/Lymphatic		**Psychiatric**	
Gastrointestinal			Bleeding Abnormalities		Alzheimer's
	Cancer: Colon, Liver		Leukemia / Lymphoma		Anxiety
	Colitis		Sickle Cell Disease		Bi-Polar Disorder
	Hepatitis		Temporal Arthritis		Depression
	Inflammatory Bowel Disease		Cancer:		Learning Disability
					Schizophrenia
Genitourinary		**Immunologic**			
	Prostate / BPH		Autoimmune Disorders	**Respiratory**	
	Renal Disease (Kidney)		HIV / AIDS		Asthma
	Sexually Transmitted Disease		Lupus		COPD
	Syphilis		Sarcoidosis		Emphysema
			Sjogren's Syndrome		Lung Cancer
Pregnant or Nursing					Tuberculosis
❑ Pregnant ❑ Nursing					

Family History:

	Relationship to Patient			Relationship to Patient	
	Amblyopia/Lazy Eye			Cancer	
	Blindness			Diabetes	
	Cataracts			Heart Disease	
	Glaucoma			Stroke	
	Retinal Detachment			Thyroid Disease	
	Macular Degeneration			Other	

Please List All Ocular Surgeries:

Procedure:_____ Year:_____ Which Eye?: _____ Dr._____

Procedure:_____ Year:_____ Which Eye?: _____ Dr._____

Procedure:_____ Year:_____ Which Eye?: _____ Dr._____

Procedure:_____ Year:_____ Which Eye?: _____ Dr._____

Please List Other Surgeries:

Procedure:_____ Year:_____ Dr._____

Procedure:_____ Year:_____ Dr._____

Procedure:_____ Year:_____ Dr._____

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