

SEATTLE EYE M.D.S - Patient Medical History Report

Patient: Last Name _____ First _____ M.I. _____ Soc. Security # _____ Birthdate _____

Please answer the following questions about your vision history:

1. Do you currently wear glasses? Yes No If YES, how long have you had your latest glasses? _____
2. Do you wear contact lenses? Yes No If YES, what type? Soft Hard What brand? _____
How often do you replace your lenses? _____ Overnight wear? Yes No
3. Have you had laser refractive surgery? (LASIK, PRK) Yes No If YES, list date _____
4. Are you required to wear protective eyewear? Yes No If YES, for what reason? Occupation Sports Monocular
5. Are you having difficulties with your current vision? Yes No If YES, what type? (Check all that apply) Distance (e.g., driving)
 Near (e.g. reading) Intermediate (e.g. computer screen, arm's length) Driving at night Other _____

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions? (e.g., diabetes, high blood pressure, arthritis, etc)?
Yes No If YES, please explain: _____
2. Have you ever had any eye disease? (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
Yes No If YES, please explain: _____
3. Have you ever had any surgery?
Yes No If YES, please provide date and reason _____
4. Have you ever been hospitalized?
Yes No If YES, please provide date and reason _____
5. Do you take any medications?
Yes No If YES, please list: _____
Do you take any eye medications: _____
Yes No If YES, please list: _____
6. Do you have any drug or food allergies?
Yes No If YES, please list: _____

Review of Systems

Do you currently have any of the follow problems?

	Yes	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g. chest pain, irregular heart beat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinal problems (e.g. pain or discomfort, blood in urine).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (e.g. rashes, excessive dryness).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g., depression, anxiety).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

Yes No If YES, please specify: _____

Do you smoke? Yes No If Yes, how much? _____

Do you drink alcohol? Yes No If Yes, how much? _____

Comments _____

Signature _____

Date _____