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	☐	☐	
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	
Urinal problems (e.g. pain or discomfort, blood in urine)	☐	☐	
Skin problems (e.g. rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	☐	☐	
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (e.g., depression, anxiety)	☐	☐	

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