WASHINGTON EYE CARE

MEDICAL HISTORY FORM

Many of these conditions or their treatments may affect your eyes. If a physician has ever indicated that you suffer from any of the following, please check each one that applies to you:

☐ Chronic fever, unexpected gain or loss of weight

☐ Ear, nose or throat problems (deafness, sinus)

☐ Heart problems (e.g. chest pain, irregular beat)

☐ Intestinal problems (e.g. heartburn, pain, diarrhea)

☐ Genitourinary problems (e.g. pain, bladder problem)

☐ Gland problems (e.g. thyroid, hormonal)

☐ Lung problems (shortness of breath, asthma, bronchitis)

☐ Skin problems (rashes, exzema, dermatitis)

☐ Muskuloskeletal (e.g. muscle or joint aches, swelling)

☐ Neurological problems (headache, numbness weakness)

☐ Bleeding or blood problems

☐ Psychiatric problems (e.g. anxiety, depression)

☐ Cancer, tumor or growth

☐ Have you ever had anything similar to asthma? ☐ **Yes** ☐ **No**

Do you have any difficulty getting around? ☐ **Yes** ☐ **No**

Any difficulty looking after yourself? ☐ **Yes** ☐ **No**

Any difficulty in shopping, cooking? ☐ **Yes** ☐ **No**

Do you live alone? ☐ **Yes** ☐ **No**

Do you drive? ☐ **Yes** ☐ **No**

Are you a computer user? ☐ **Yes** ☐ **No**

Do you have diabetes? ☐ **Yes** ☐ **No**

Is there diabetes in your family? ☐ **Yes** ☐ **No**

Do you drink alcohol? ☐ **Yes** ☐ **No** How much? __

Do you eat a balanced diet? ☐ **Yes** ☐ **No**

Do you smoke? ☐ **Yes** ☐ **No** How much? _____

Email: _____

What type of work do you do? _____
(if retired, please say what you did before retiring)

Are you under medical treatment now? ☐ **Yes** ☐ **No**

Do you have any infection that could cause problems with immunity (immuno deficiency)? ☐ **Yes** ☐ **No**

Please list ***ALL*** medicines you are taking, including *eye drops*, *insulin*, *aspirin*, *vitamins*, and any *herbals*.

Please list ***ALL*** surgeries you have ever had:

Please list any allergies including allergies to medications:

PHYSICIAN INFORMATION

Who is your general physician? _____ Did He/She refer you here? ☐ **Yes** ☐ **No**

An examination of the back part of the eye may require dilating the pupil. Please be aware that this may make your vision less clear. Please use caution when walking and do not drive until you have recovered sufficiently to do so safely.

Signature: _____ Date: _____

*There will be a $35 charge for all returned checks.