EyeHealth NORTHWEST

PATIENT HISTORY FORM

NAME:

DOB:

List any medications you take: ☐ None	
Medication	Dose if known

List all Allergies to Medications:	Reaction / Problem:

List all major illnesses or injuries ☐ None
(diabetes, high blood pressure, Emphysema, heart attacks,

List all eye illnesses or injuries (crossed / lazy eye, cataract, glaucoma, macular degeneration, abrasions, etc) ☐ None

List any surgeries you have had: ☐ None

Do you have a **family** history of (Please list the relationship of the family member to you): ☐ None

☐ Blindness ____________________ ☐ Macular Degeneration ____________________
☐ Glaucoma ____________________ ☐ Diabetes ____________________

TODAY, Do you currently have any problems in the following areas? If, "Yes", please explain problem.

General / Constitutional
Yes No
☐ ☐ Fatigue
☐ ☐ Fever

HEENT / Ear, Nose & Throat
Yes No
☐ ☐ Sinus Problems
☐ ☐ Vertigo

Respiratory
Yes No
☐ ☐ Asthma
☐ ☐ Cough

Gastrointestinal
Yes No
☐ ☐ Diarrhea

Psychiatric
Yes No
☐ ☐ Emotional Changes

Genitourinary
Yes No
☐ ☐ Painful Urination
☐ ☐ Genital Lesions

Metabolic / Endocrine
Yes No
☐ ☐ Cold Intolerance
☐ ☐ Heat intolerance
☐ ☐ Excessive thirst
☐ ☐ Excessive hunger
☐ ☐ Excessive urination

Neurological
Yes No
☐ ☐ Dizziness
☐ ☐ Headache

Skin / Integumentary
Yes No
☐ ☐ Rash
☐ ☐ Skin lesion

Cardiovascular
Yes No
☐ ☐ Chest Pressure or Discomfort
☐ ☐ Irregular Heartbeat/Palpitations

Musculoskeletal
Yes No
☐ ☐ Difficulty walking
☐ ☐ Joint swelling
☐ ☐ Muscle weakness

Hematologic / Lymph
Yes No
☐ ☐ Bleeding
☐ ☐ Bruising

Immunologic
Yes No
☐ ☐ Food allergies
☐ ☐ Seasonal Allergies

Explanation / Other Health Problems: ____________________

____

____

Preferred Language: ____________________

Preferred Pharmacy: ____________________

Occupation: ____________________

Social History – Do you?:
Yes No
☐ ☐ Smoke ______ packs / day Years smoked ________
☐ ☐ Formers Smoker? Quit how long ago? ____________
☐ ☐ Drink Alcohol ______ drinks / day
☐ ☐ Caffeine, amount per day ______________
☐ ☐ Drug Use / Abuse Type: ________________

****We are required to include the following information in your Health Record by the Centers for Medicare/Medicaid Services****

Race: ☐ White ☐ Asian ☐ Decline to Answer
☐ American Indian or Alaska Native ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Other ______________

Ethnicity: ☐ Decline to Answer
☐ Hispanic or Latino
☐ Not Hispanic or Latino