

Eye Care Specialists Northwest, PLLC

The Children's Eye Doctors

The Family Eye Doctors

Woodlawn Optical

male female

Name _____

Date of Birth _____

Patient Medical History Record

| Does the patient have any of the following problems? | Yes | No | If Yes, please explain: |
|---|-----|-----------------|-------------------------|
| Ear/Nose/throat problems (e.g. sinus problems, sore throat, infections, hard of hearing) | | | |
| Heart problems (e.g. irregular heart beats, chest pains, hypertension) | | | |
| Respiratory problems (e.g. wheezing, cough, short of breath, asthma, allergies) | | | |
| Gastrointestinal problems (e.g. diarrhea, vomiting, heartburn) | | | |
| Urinary problems (e.g. pain or discomfort, blood in urine, kidney disease) | | | |
| Skin problems (e.g. rashes, dryness, eczema) | | | |
| Neurologic problems (e.g. headaches, numbness, stroke, seizures) | | | |
| Psychiatric problems (e.g. hyperactive, anxiety, depression, ADD, ADHD) | | | |
| Musculoskeletal problems (e.g. muscle aches, joint pain, arthritis) | | | |
| Endocrine problems (e.g. diabetes, thyroid) | | | |
| Chronic fever, unexpected weight loss/gain, fatigue | | | |
| Have you ever been hospitalized? | | | |
| Current Medications (including eye drops, vitamins and naturpathic) | | | |
| Allergies | | doctor reviewed | date |

Eye History

| Does the patient have any of the following eye problems? | Yes | No | Does the patient have any of the following eye problems? | Yes | No | Family History |
|--|-----|----|---|-----|----|----------------|
| Blurred vision | | | Cataract | | | |
| Double vision | | | Glaucoma | | | |
| Headache | | | Detached retina | | | |
| Eye pain/strain | | | Diabetic neuropathy | | | |
| Redness | | | Macular degeneration | | | |
| Droopy eye lid | | | Injury | | | |
| Wandering eye | | | Astigmatism | | | |
| Crossed eye | | | Color blindness | | | |
| Head tipping/tilting/turning | | | Please write in the answer to the following questions: Age at first exam: _____ most recent exam date: _____ Exam performed by: _____ Eye treatment: ___ glasses, ___ contact lenses, ___ bifocals, ___ patching, ___ surgery, ___ vision therapy/exercises If in school, what grade _____ learning disabilities _____ Reading difficulties _____ Birth history (for patients under 5 yrs of age): _____ Birth weight _____ Was the patient premature? <input type="checkbox"/> yes <input type="checkbox"/> no If Yes, how early? _____ | | | |
| Lumps or swelling | | | | | | |
| Light sensitivity | | | | | | |
| Crusting discharge | | | | | | |
| Itching/burning/scratching | | | | | | |
| Excessive rubbing/blinking | | | | | | |
| | | | | | | |

FOR OFFICE USE ONLY

Current Problem / New Medical History

Surgical History / Date

Referred By: _____

Primary Care Doctor