EVERGREEN EYE CENTER
Leading-edge, patient-centered care.

MEDICAL HISTORY FORM

Patient's Name: ____ **Date of Birth: ____________________**

Patient Medical History (circle yes for all that apply)

High blood pressure	Yes	Pacemaker, stent	Yes
High cholesterol	Yes	Heart conditions	Yes
Heart conditions	Yes	(If yes, please specify type: _______________)	
Stroke	Yes	Cancer	Yes
Emphysema	Yes	(If yes, please specify type: ________________)	
Asthma	Yes	Arthritis	Yes
Dementia/Alzheimer's	Yes	(If yes, please specify type: ________________)	
Kidney disease	Yes	Diabetes	Yes
Anemia	Yes	(If yes, please specify type: ________________)	
Lupus	Yes	(Last A1C: _________ Last Blood Sugar: _______)	
Multiple sclerosis	Yes		
Sjogren's	Yes		
Thyroid disease	Yes	Other medical conditions:	
HIV	Yes	____	
Hepatitis B or C	Yes	____	
MRSA	Yes	____	
Tuberculosis	Yes	____	
Neurofibromatosis	Yes	____	
Bleeding disorder	Yes		

Family History (circle yes for all that apply)

Amblyopia	Yes	Thyroid	Yes
Glaucoma	Yes	Hypertension	Yes
Corneal disease	Yes	Stroke	Yes
Keratoconus	Yes	Heart conditions	Yes
Corneal Transplant	Yes	(If yes, please specify type: ________________)	
Macular Degeneration	Yes	Diabetes	Yes
Diabetic Retinopathy	Yes	(If yes, please specify type: ________________)	
Retinal Detachment	Yes	Cancer	Yes
Retinitis Pigmentosa	Yes	(If yes, please specify type: ________________)	
Other Eye Problems:		Other medical conditions:	
____		____	
____		____	

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Patient Eye History (circle yes for all that apply)

Amblyopia	Yes	Keratoconus	Yes
Blepharitis	Yes	Macular degeneration	Yes
Cancer (in or around eye)	Yes	Muscle surgery	Yes
Cataract	Yes	Ocular trauma	Yes
Cataract surgery	Yes	Refractive Procedure (i.e. LASIK, RK, LASEK, PRK)	Yes
Diabetic laser	Yes	Retinal detachment	Yes
Double vision	Yes	Wandering/lazy eye	Yes
Dry eyes	Yes	Other eye disease or surgery: ______________________	
Eyelid surgery	Yes	____	
Glaucoma	Yes	____	
Herpes simplex	Yes		
Herpes zoster	Yes		

Medications
(Please list all current medications, over-the-counter medications, vitamins, and medication strengths.)

Medications	Strength	Medications	Strength
_________________________	____________	_________________________	____________
_________________________	____________	_________________________	____________
_________________________	____________	_________________________	____________

Allergies
(Please list all allergies to medications and the specific allergic reaction.)

Allergies	Reaction	Allergies	Reaction
_________________________	____________	_________________________	____________
_________________________	____________	_________________________	____________

Past Surgeries

Surgery	Year	Surgery	Year
_________________________	____________	_________________________	____________
_________________________	____________	_________________________	____________

Social History (circle yes for any that apply)

Current Occupation: __________________________

Activities and Hobbies: ________________________

____

____

Recreational drug use Yes

(if yes, please specify type: _______________ _____)

Alcohol Consumption Yes

(If yes, please specify times per week: ____ _____)

Smoking Status Never, Former, Current

(If former, please specify year quit: _______ ____)

(If current, please specify year begun: __________)