SEATTLE OPHTHALMOLOGY
Medical History

Name: _____ **Today's Date:** _____

Date of birth: _____ **Referring physician:** _____

Do you have problems with, or are being treated for:

	NO	YES		NO	YES
Diabetes	⬭	⬭	Neurological/memory	⬭	⬭
High blood pressure	⬭	⬭	Skin, breast	⬭	⬭
Hearing Loss/Hearing Aid	⬭	⬭	Muscles/joint	⬭	⬭
Fever, weight loss	⬭	⬭	Urinary/kidney	⬭	⬭
Breathing/ asthma	⬭	⬭	Migraines/ headaches	⬭	⬭
Heart disease/blood vessels	⬭	⬭	Poor blood circulation	⬭	⬭
Thyroid disease/immune	⬭	⬭	Dizziness/blackouts	⬭	⬭
Ear, nose, throat, sinus	⬭	⬭	Double/blurry vision	⬭	⬭
Digestive, abdominal	⬭	⬭	Other:_____	⬭	⬭

Please explain any "yes" answers: _____

_____

_____

Please list any surgeries you may have had: _____

_____

_____

Please list any current medications: _____

_____

_____

Please list any drug allergies: _____

Family history

Do any of your family members have:

	NO	YES		NO	YES
Diabetes	⬭	⬭	Retinal Detachment	⬭	⬭
Cancer	⬭	⬭	Blindness	⬭	⬭
Heart Disease	⬭	⬭	Neurological Problems	⬭	⬭
Glaucoma	⬭	⬭	Other :_____	⬭	⬭
Macular Degeneration	⬭	⬭			

Social history

	NO	YES	Frequency and amount
Do you consume alcohol?	⬭	⬭	_____
Do you smoke or chew tobacco?	⬭	⬭	_____
Do you use recreational drugs?	⬭	⬭	_____
Do you drive?	⬭	⬭	_____

What is/was your occupation? _____ (current/retired)