

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	<input type="radio"/>	<input type="radio"/>	Neurological/memory	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	Skin, breast	<input type="radio"/>	<input type="radio"/>
Hearing Loss/Hearing Aid	<input type="radio"/>	<input type="radio"/>	Muscles/joint	<input type="radio"/>	<input type="radio"/>
Fever, weight loss	<input type="radio"/>	<input type="radio"/>	Urinary/kidney	<input type="radio"/>	<input type="radio"/>
Breathing/ asthma	<input type="radio"/>	<input type="radio"/>	Migraines/ headaches	<input type="radio"/>	<input type="radio"/>
Heart disease/blood vessels	<input type="radio"/>	<input type="radio"/>	Poor blood circulation	<input type="radio"/>	<input type="radio"/>
Thyroid disease/immune	<input type="radio"/>	<input type="radio"/>	Dizziness/blackouts	<input type="radio"/>	<input type="radio"/>
Ear, nose, throat, sinus	<input type="radio"/>	<input type="radio"/>	Double/blurry vision	<input type="radio"/>	<input type="radio"/>
Digestive, abdominal	<input type="radio"/>	<input type="radio"/>	Other: _____	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	Retinal Detachment	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	Blindness	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	Neurological Problems	<input type="radio"/>	<input type="radio"/>
Glaucoma	<input type="radio"/>	<input type="radio"/>	Other : _____	<input type="radio"/>	<input type="radio"/>
Macular Degeneration	<input type="radio"/>	<input type="radio"/>			

Social history

	NO	YES	Frequency and amount
Do you consume alcohol?	<input type="radio"/>	<input type="radio"/>	_____
Do you smoke or chew tobacco?	<input type="radio"/>	<input type="radio"/>	_____
Do you use recreational drugs?	<input type="radio"/>	<input type="radio"/>	_____
Do you drive?	<input type="radio"/>	<input type="radio"/>	_____
What is/was your occupation?			_____ (current/retired)