**Emerald City Eye Care**

**Patient Health History**

**Name Today’s Date**

**Primary Care Physician Date of last eye exam**

**Reason for today’s visit**

**Have you ever been diagnosed with any of the following?**

**General Medical History**

| **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Arthritis** |  |  | **High blood pressure** |  |  | **Seizures or Fainting** |
|  |  | **Asthma** |  |  | **HIV, STD’s (Confidential)** |  |  | **Stomach/Intestinal** |
|  |  | **Blood Vessel Problems** |  |  | **Kidney Problems** |  |  | **Stroke** |
|  |  | **Cancer** |  |  | **Frequent Headaches** |  |  | **Thyroid Problems** |
|  |  | **Diabetes** |  |  | **Migraines** |  |  | **Tuberculosis** |
|  |  | **Heart Problems** |  |  | **Psychiatric** |  |  | **Skin Problems** |

**Please explain any yes answers:**

**Are you pregnant? Do you smoke? Do you consume alcohol?**

**Have you had any surgeries? Please list by date and type:**

| **Please list any medications (prescription and non-prescription) you are currently taking:** | **Please list any drug allergies you have:** |
| --- | --- |

**Ocular History**

| **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Cataracts** |  |  | **Floaters/flashing lights** |  |  | **Macular degeneration** |
|  |  | **Corneal disease** |  |  | **Double vision** |  |  | **Retinal disease** |
|  |  | **Crossed eyes/lazy eye** |  |  | **Glaucoma** |  |  | **Other eye disorders** |
|  |  | **Eye infections** |  |  | **Iritis** |  |  | **Eye injury** |

**Please explain any yes answers:**

**Have you ever had eye surgery? If yes, please explain**

**Has anyone in your family (blood relative) been diagnosed with any of the following?**

| **Yes** | **No** |  | **Yes** | **No** |  | **Yes** | **No** |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Glaucoma** |  |  | **Corneal disease** |  |  | **Retinal disease** |
|  |  | **Cataracts** |  |  | **Macular degeneration** |  |  | **Diabetes** |
|  |  | **High blood pressure** |  |  | **Crosse eyes/lazy eye** |  |  | **Other conditions** |

**Please explain any yes answers:**

**Would you like your eyes dilated today? Yes\_\_\_\_\_ No\_\_\_\_\_Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**