# Welcome to Tumwater Eye Center Inc. and VUE: Vision Uniquely Experienced
# Health History Form

Patient Name: _____ Patient DOB: _____
Previous Eye Doctor: _____ Last Eye Exam: _____
Primary Care Doctor: _____ Last Medical Exam: _____
Preferred Pharmacy: _____

| List All Medications: (Vitamins, Herbals, Birth Control, and Eye Meds) | | List Allergies to Medications |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## MEDICAL HISTORY:

| | | |
|---|---|---|
| No __ Yes __ | Cardiovascular (Heart Disease, A-Fib) | Explain |
| No __ Yes __ | High Blood Pressure | Explain |
| No __ Yes __ | High Cholesterol | Explain |
| No __ Yes __ | Vascular Disease | Explain |
| No __ Yes __ | Ear, Nose, Throat | Explain |
| No __ Yes __ | Respiratory (Asthma, Emphysema, COPD) | Explain |
| No __ Yes __ | Allergies/Hay Fever | Explain |
| No __ Yes __ | Gastrointestinal (Colitis/IBD/GERD) | Explain |
| No __ Yes __ | Genital, Kidney, Bladder | Explain |
| No __ Yes __ | Skin/Dermatology Problems | Explain |
| No __ Yes __ | Headaches/Migraines | Explain |
| No __ Yes __ | Neurological (MS, Seizures, Bells Palsy) | Explain |
| No __ Yes __ | Mental Health (Anxiety, Depression, Bipolar) | Explain |
| No __ Yes __ | Diabetes | Explain |
| No __ Yes __ | Thyroid or Other Glands | Explain |
| No __ Yes __ | Arthritis, Other Joint/Muscle Pain | Explain |
| No __ Yes __ | Cancer | Explain |
| No __ Yes __ | Blood Disorder, Anemia | Explain |
| No __ Yes __ | Pregnant | Explain |
| No __ Yes __ | Stroke | Explain |
| No __ Yes __ | Other Disease or Condition | Explain |

## EYE HISTORY:

| | | |
|---|---|---|
| No __ Yes __ | Previous Eye Surgery | Explain |
| No __ Yes __ | Cataracts/Cataract Surgery | Explain |
| No __ Yes __ | Retinal Detachment | Explain |
| No __ Yes __ | Macular Degeneration | Explain |
| No __ Yes __ | Glaucoma | Explain |
| No __ Yes __ | Dry Eyes or Allergies (burning, irritation) | Explain |
| No __ Yes __ | Glare/Light Sensitive | Explain |
| No __ Yes __ | Flashes of Light/Floaters | Explain |
| No __ Yes __ | Eyelid Swelling/Irritation | Explain |
| No __ Yes __ | Discharge/Mucus/Watering | Explain |
| No __ Yes __ | Eye Injuries | Explain |
| No __ Yes __ | Other Eye Diseases/Conditions | Explain |

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## CONTACT LENS/SPECIAL EYEWEAR NEEDS:

| | |
|---|---|
| Do you wear contacts __ No __ Yes Brand: | |
| Do you use separate computer glasses? | |
| Do you use occupational or safety glasses? | |
| How much time daily do you spend with power tools, firearms? | 0 2 4 6 8 10 Hrs |
| How much time daily do you spend outdoors reading, boating? | 0 2 4 6 8 10 Hrs |
| How much time daily do you spend on a computer? | 0 2 4 6 8 10 Hrs |
| How much time is spent on digital devices per day? | 0 2 4 6 8 10 Hrs |
| List any other hobbies/interests you may have that you use glasses for: | |

## PERSONAL/SOCIAL/GENERAL HEALTH HISTORY:

| | | | | | | |
|---|---|---|---|---|---|---|
| Do you use caffeine: | __ None | __ 1-2 cup/day | __ 3-4 cup/day | __ 5+ cups/day | | |
| Do you use alcohol: | __ None | __ Rarely | __ 1-2 /wk | __ 3-5/wk | __ 1-2/day | __ 3 or more/day |
| Do you smoke: | __ None | __ Past | __ Light | __ Heavy | | |
| Do you use chewing tobacco: | __ None | __ Past | __ Current | | | |
| Do you use cannabis: | __ None | __ 1-2 time/mo | __ 1-2 time/wk | __ 1-2 time/day | | |

## FAMILY HISTORY:

Please check all that apply to your family member

**Father**

__ Cancer __ Diabetes __ Heart Disease __ High BP __ Glaucoma __ Macular Degeneration

**Mother**

__ Cancer __ Diabetes __ Heart Disease __ High BP __ Glaucoma __ Macular Degeneration

**Siblings**

__ Cancer __ Diabetes __ Heart Disease __ High BP __ Glaucoma __ Macular Degeneration

**Children**

__ Cancer __ Diabetes __ Heart Disease __ High BP __ Glaucoma __ Macular Degeneration

I do hereby consent to and authorize the performance of all treatments and medical services deemed advisable by the physicians and staff of Tumwater Eye Center Inc. to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Name of Patient/Responsible Party (Please Print) Relationship to Patient