

Welcome to Tumwater Eye Center Inc. 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 cups/day 3-4 cups/day 5+ cups/day

Do you use alcohol: None Rarely 1-2 times/week 3-5 times/week

Do you smoke: None Past Light Heavy

Do you use chewing tobacco: None Past Current

Do you use cannabis: None Past Light Heavy

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