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: _____

Please list **ALL MEDICATIONS:** (including Vitamins, Herbal, Birthcontrol or eye meds)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any **ALLERGIES** to medication:

_____ _____ _____

IF YOU HAVE DIABETES, please indicate your blood sugar level and last A1C:

Blood Sugar Level _____ /when _____ Last A1C _____ / when _____

Do you have any of the following conditions or problems: (check all that apply & notes, if needed)

- ☐ **Significant weight gain or loss** _____
- ☐ Fatigue _____
- ☐ Fever _____
- ☐ Chronic Cough _____
- ☐ **Dry Throat or Mouth** _____
- ☐ Sinus problems, Congestion, runny nose
- ☐ Hearing problems _____
- ☐ **Heart Disease** _____
- ☐ High Cholesterol _____
- ☐ High Blood Pressure _____
- ☐ Vascular Disease _____
- ☐ **Bronchitis** _____
- ☐ Emphysema _____
- ☐ Asthma _____
- ☐ **Urinary/Bladder Problems** _____
- ☐ Kidney or Genital Problems _____
- ☐ **GI Problems, Acid Reflux, GERD** _____
- ☐ Irritable Bowel _____
- ☐ Colitis _____
- ☐ **Skeletal Disease, Muscle pain/weakness**
- ☐ **Arthritis, rheumatoid, osteo, JRA** _____
- ☐ **Eczema, Psoriasis, Rosacea** _____
- ☐ Itchy skin _____
- ☐ Acne _____
- ☐ **Neurological, MS, Dementia, Parkinsons** ____
- ☐ Balance problems, Numbness/Paralysis _____
- ☐ Seizures, Tremors, Vertigo _____
- ☐ **Mental Health issues** _____
- ☐ Anxiety, Depression _____
- ☐ Obsesive/Compulsive _____
- ☐ **Diabetes Type 1 -** since_____
- ☐ Diabetes Type 2 - since _____
- ☐ Hyperthyroid_____
- ☐ Hypothyroid _____
- ☐ **Anemia, Bleeding disorder** _____
- ☐ Nose bleeds, bleeding gums, bruising _____
- ☐ **Seasonal/Environmental Allergies** _____
- ☐ **Migraines/Headaches** _____
- ☐ **Cancer**_____
- ☐ Other _____
- ☐ **Difficulty seeing in dark or navigating at night**
- ☐ **Difficulty reading in dim light**

☐ Additional information: _____

~PLEASE COMPLETE BOTH SIDES OF THIS FORM ~

Do you or any of your family have any of the following conditions:

Diabetes		☐ Mother	☐ Father	☐ Sibling(s)	☐ Grandparent(s)
High Blood Pressure		☐ Mother	☐ Father	☐ Sibling(s)	☐ Grandparent(s)
High Cholesterol		☐ Mother	☐ Father	☐ Sibling(s)	☐ Grandparent(s)
Thyroid		☐ Mother	☐ Father	☐ Sibling(s)	☐ Grandparent(s)
Cardiovascular		☐ Mother	☐ Father	☐ Sibling(s)	☐ Grandparent(s)
Cancer		☐ Mother	☐ Father	☐ Sibling(s)	☐ Grandparent(s)
EYE HISTORY:					
Glaucoma	☐ Myself	☐ Mother	☐ Father	☐ Sibling(s)	☐ Grandparent(s)
Cataracts	☐ Myself	☐ Mother	☐ Father	☐ Sibling(s)	☐ Grandparent(s)
Macular Degeneration	☐ Myself	☐ Mother	☐ Father	☐ Sibling(s)	☐ Grandparent(s)
Retinal Detachment	☐ Myself	☐ Mother	☐ Father	☐ Sibling(s)	☐ Grandparent(s)
Crossed Eye	☐ Myself	☐ Mother	☐ Father	☐ Sibling(s)	☐ Grandparent(s)
Blindness	☐ Myself	☐ Mother	☐ Father	☐ Sibling(s)	☐ Grandparent(s)
Other_____	☐ Myself	☐ Mother	☐ Father	☐ Sibling(s)	☐ Grandparent(s)

Previous eye surgery: _____

SOCIAL HISTORY

Ethniciy: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Answer

Race: ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ Unknown ☐ Decline to Answer ☐ Other: _____

Height: _____ Weight: _____ Eye color: _____

Do you wear contact lenses? ☐ No ☐ Yes Brand:_____Age of Contacts: _____

Do you require safety glasses? ☐ No ☐ Yes

Do you use a separate pair of computer or reading glasses? ☐ No ☐ Yes

Do you smoke:	☐ Never	☐ Past	☐ Light	☐ Heavy
Do you use alcohol:	☐ None	☐ Rarely	☐ 1-2 / week	☐ 3-5 / week
Do you use cannabis:	☐ None	☐ Past	☐ Light	☐ Heavy
How many hours/day on digital device or computer:	☐ 0-3 hours	☐ 3-6 hours	☐ 6-10 hours	☐ 10 hours +
Daily caffeine use:	☐ None	☐ 1-2 cups	☐ 3-4 cups	☐ 5+ cups
Do you have sleep apnea:	☐ No	☐ Yes - no CPAP		☐ Yes - using CPAP

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

_____ _____
Printed Name of Patient/Responsible Party Relationship to Patient

~ PLEASE COMPLETE BOTH SIDES OF THIS FORM ~