LIFESTYLE EYE CENTER
Healthy You – Healthy Eyes

1610 Penny Ln
Walla Walla, WA 99362-4477
ph: (509) 540-3937 **fx**: (509) 540-3938

HEALTH HISTORY

First Name _____ **Last Name** _____ **Birthdate** _____

Describe the reason for your appointment in your own words; please be specific:

_____

_____

_____

When was your last eye exam? _____ Who was this eye exam with? _____

Do you wear contact lenses? ❑ No ❑ Yes If yes, do you sleep with your contacts in? ❑ No ❑ Yes

YOUR CURRENT EYE MEDICATIONS AND/OR THERAPIES (include hot/cold compresses, artificial tears, etc.) ❑ None

Eye Medication/Therapy	Number of times per day	Last used	Which eye(s)?
_____	_____	_____	Right Left Both
_____	_____	_____	Right Left Both
_____	_____	_____	Right Left Both
_____	_____	_____	Right Left Both

EYE SURGERIES/LASER TREATMENT (list any you have had; e.g. cataract, LASIK, cornea, glaucoma, retina, etc.) ❑ None

Operation	Which eye?	Location of procedure	Surgeon	Date

EYE HISTORY (have you or any of your blood relatives had any of the following eye conditions; ☑ all that apply)

Your eye conditions	Which eye?
❑ Cataract	Right Left Both
❑ Color blindness	Right Left Both
❑ Corneal disorder	Right Left Both
❑ Diabetic retinopathy	Right Left Both
❑ Dry eyes	Right Left Both
❑ Glaucoma	Right Left Both
❑ "Lazy eye" or muscle imbalance	Right Left Both
❑ Macular degeneration	Right Left Both
❑ Retinal detachment	Right Left Both
❑ Rosacea	Right Left Both
❑ Uveitis/Iritis	Right Left Both
❑ **None of the above**	

Family eye conditions	Relation to you
❑ Corneal disorder	
❑ Glaucoma	
❑ Macular degeneration	
❑ Retina problems	
❑ Uveitis/Iritis	
❑ **None of the above**	
❑ **Family history unknown**	

Describe any head or eye injuries that you have had: _____

_____

_____

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YOUR PAST SURGERIES OR HOSPITALIZATIONS (please include dates) ❑ None

Case	Year	Case	Year

Attach list (typed or printed neatly) if more convenient or if there are more than can fit here.

YOUR PAST MEDICAL HISTORY (☑ all that apply; any medical condition you have had) ❑ None

Condition		Details	Condition		Details
Cardiovascular			**Infection**		
Anemia	❑		AIDS or HIV+	❑	
Blood clots	❑		Hepatitis	❑	Type: _____
Heart attack	❑	Date(s): _____	**Musculoskeletal**		
Heart disease	❑	Type: _____	Arthritis	❑	Type: _____
High blood pressure	❑		**Pulmonary**		
High cholesterol	❑		Asthma	❑	
Irregular/rapid heart rate	❑		Emphysema/COPD	❑	
Pacemaker/defibrillator	❑	Last reading: _____	**Neurologic**		
Collagen Vascular Disease			Brain injury	❑	Date(s): _____
Lupus	❑		Dementia/Alzheimer's	❑	
Sjogren's disease	❑		Depression	❑	
Endocrine			Migraine headaches	❑	
Diabetes	❑	Type: _____	Parkinson's	❑	
Organ transplant	❑	Type: _____	Seizures	❑	
Thyroid disease	❑		Stroke	❑	
Renal (kidney) disease	❑		Vertigo	❑	
Gastrointestinal			**Other:**		
Crohn's disease	❑				
GERD/acid reflux	❑				
Ulcerative colitis	❑				

Cancer or tumor ❑ Type/Location: Any chemo or radiation? ❑ No ❑ Yes

FAMILY MEDICAL HISTORY (☑ check any a blood relative has had) ❑ None ❑ Family history unknown

Condition	☑	Relation to you	Condition	☑	Relation to you
Cancer	❑		Migraines/headaches	❑	
Diabetes	❑		Renal (kidney) disease	❑	
Heart disease	❑		Stroke	❑	
High blood pressure	❑		Thyroid disease	❑	

Other:

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CURRENT MEDICATIONS (list **all** medications and supplements you currently use ***other than*** eye medications) ❑ None

Drug Name	Dosage	Frequency	Drug Name	Dosage	Frequency

Attach list (typed or printed neatly) if more convenient or if there are more than can fit here.

ALLERGIES (drug or medical supply allergies including latex, iodine, tape, anesthetics, etc.) ❑ None

Allergy	Reaction	Allergy	Reaction

Attach list (typed or printed neatly) if more convenient or if there are more than can fit here.

LIFESTYLE & SOCIAL HISTORY (please complete entire section)

Alcohol History
❑ Never
❑ Occasionally
❑ Daily/frequently
❑ Would like to quit

Tobacco History
❑ Never used tobacco ❑ Would like to quit
❑ Currently smoke tobacco → Been a smoker for how long? _____
❑ Chew / Use smokeless → Used smokeless for how long? _____
❑ Former tobacco user → When did you discontinue? _____

Recreational drug use? ❑ No ❑ Yes
If yes, which substance? _____
❑ Would like help to quit

Caffeine use? ❑ No ❑ Yes
If yes, how many cups daily? _____

Lifestyle factors
How many 8 oz. glasses of water have you had in the past 24 hours? _____
How much fresh air do you get daily? ❑ None ❑ less than 1 hour per day ❑ more than 1 hour per day
How often do you exercise? ❑ Daily ❑ _____times weekly ❑ Occasionally
How many cups of fresh fruits/vegetables daily? _____
Date of last health exam: _____ With whom? _____

Are you pregnant? ❑ No ❑ Yes
Are you breastfeeding? ❑ No ❑ Yes

Do you use hearing aids? ❑ No ❑ Yes
Do you use dentures? ❑ No ❑ Yes
→ Upper: ❑ Full ❑ Partial
→ Lower: ❑ Full ❑ Partial

AUTHORIZATION:

This information provided on this questionnaire is complete and accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment.

_____ _____
Signature of Patient or Authorized Party **Date**

_____ _____
Print Name (if not patient) **Relationship**

1.15.2018