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

>ALL MEDICATIONS (attach a list of **all** medications and supplements you currently use ***other than*** eye medications) ❑ None

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?
❑ 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**	

Other:

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

_____

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.

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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:					

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? _____

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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		Do you use hearing aids?	❑ No ❑ Yes	
Are you breastfeeding?	❑ 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**

5.19.2017