SEATTLE VISION CARE CENTER

Patient Health History

Patient Name ______________________________ Date ________________

Name of Primary Care Provider ________________ City __________ Phone ______________

Primary reason for your visit today ______________________________________

Emergency Contact ________________ Phone ______________ Relationship ____________

Do you wear glasses? ☐ Yes ☐ No ☐ All the time ☐ Occasionally ☐ Distance only ☐ Reading only

Do you wear contacts? ☐ Yes ☐ No ☐ Soft ☐ RGP ☐ CRT ☐ Scleral

Have you had any eye surgery? ☐ Yes ☐ No If yes, why? ______________________

Are you taking any medication? ☐ Yes ☐ No If yes, why? ______________________

Are you interested in: ☐ Contact Lenses ☐ Laser Vision Correction ☐ CRT

Do you consume alcohol? ☐ Never ☐ Occasionally ☐ Daily

Do you smoke tobacco products? ☐ Yes ☐ No If quit, how long ago (years) ☐ 1-4 ☐ 5-9 ☐ 10+

Are you allergic to any medication? ☐ Yes ☐ No If yes, what? ______________________

HAVE YOU EVER BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS?

Condition		Condition	
Allergies / Hayfever	☐ Yes	Cataracts	☐ Yes
Headaches / Migraines	☐ Yes	Corneal Abrasion	☐ Yes
Seizures	☐ Yes	Retinal Detachment	☐ Yes
Anemia / Bleeding Disorders	☐ Yes	Iritis / Uvetis	☐ Yes
High Cholesterol	☐ Yes	Eye Infection	☐ Yes
Thyroid	☐ Yes	Lazy Eye	☐ Yes
Heart / Vascular Disease	☐ Yes	Arcus	☐ Yes
Rheumatoid Arthritis	☐ Yes	Psychiatric Disorder	☐ Yes
Asthma	☐ Yes	HIV/AIDS	☐ Yes
Depression / Anxiety	☐ Yes	Kidney Disorder	☐ Yes
Diabetes	☐ Yes	Autoimmune Disease	☐ Yes
Hypertension	☐ Yes	Neurological	☐ Yes
Cancer	☐ Yes	Glaucoma	☐ Yes
Diabetic Retinopathy	☐ Yes	Other ____________	

DO YOU OR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING CONDITIONS?

Condition		Condition	
Blurry Vision	☐ Yes	Floater / Spots	☐ Yes
Burning	☐ Yes	Grittiness	☐ Yes
Tearing	☐ Yes	Dryness	☐ Yes
Turned / Crossed Eye	☐ Yes	Eyestrain	☐ Yes
Itchiness	☐ Yes	Double Vision	☐ Yes
Glare / Light Sensitivity	☐ Yes	Other ____________	

FAMILY MEDICAL EYE HISTORY (list who in your family has the following conditions)

Condition		Condition	
Blindness / Loss of Vision	__________	Crossed / Lazy Eye	__________
Glaucoma	__________	Cataracts	__________
Macular Degeneration	__________	Corneal Problems	__________
Retinal Problems	__________	High Blood Pressure	__________
Heart Disease	__________	Thyroid Disease	__________
Diabetes	__________	Double Vision	__________

STAFF INITIALS