ENUMCLAW VISION CLINIC

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Name _____ Today's Date _____

General Eye History

Please circle any of the following that apply to the history of your eyes:

Cataract(s)	Glaucoma	Macular Degeneration
Crossed Eye	Lazy Eye	Eye Injury
Detached Retina	Eye Surgery	Eye Infection
Seasonal Allergy Symptoms	Diabetic Retinopathy	LASIK procedure
Wear Glasses	Wear Contact Lenses	Lens Implants

Last Eye Exam (year) _____ Eye Doctor _____

Vision needs for:

Current Occupation _____

Hobbies / Interests _____

Circle as applies : Tobacco never daily occasionally Alcohol never daily occasionally

General Health History

Please list any major surgeries, injuries, or hospitalizations that you have had

_____

_____

Primary Care Doctor: _____ Last Visit: _____(yr)

Medications

Please list names of all (non-eye) medications that you are currently taking

_____

Medications Cont'd

Please list any drugs / medications to which you have an allergic reaction

_____

Please list any Prescription (Rx) EYE medications that you are taking

_____

Please list any OverThe Counter (OTC) eye medications/solutions that you use

_____

Please list any Vitamins that you are specifically taking for eye health

_____

Significant Family Health History

Please list general medical conditions / illnesses affecting your parents or siblings

_____

Please list any EYE conditions of which you are aware in parents or siblings

_____

Current General Health

Circle all conditions/diagnoses that you are currently being treated for, or are experiencing:

Infection Ear, Nose, Throat	High Blood Pressure	Heart Failure
Heart Rhythm	Asthma	Emphysema (COPD)
Diabetes (I or II)	Ulcers	HIV/AIDs
Intestinal Disease	Kidney Disease	Bladder Disease
Thyroid Dysfunction	Arthritis	Muscle Pain
Skin Disorder	Neurological Disorder	Seasonal Allergies
Depression	Psychological Condition	Headaches
Cancer	STD (genital disease)	Hormonal Imbalance
High Cholesterol	Multiple Sclerosis	Reflux / GERD