West Linn Vision Center
MEDICAL HISTORY

Name: _____ Birth Date: _____ Today's Date: _____

Date of last eye exam: _____ Name of Doctor/Clinic_____

Height: _____ Weight:_____ Sex: M F

Primary Care Physician/Location: _____

Have you had any recent major illnesses / injuries / surgeries?: _____

Have you ever had LASIK, PRK or Keratotomy? Date and facility:_____ _____

Are you currently taking: Flomax Coumadin Plavix Aspirin Rapaflo Uroxatral Minipress Cardura Hytrin Plaquenil

Current medications and what they are used for (prescription and over-the-counter): _____

_____

Allergies to any medications?: _____

Do you **currently** have any problems in the following areas?

Review of Body Systems	**YES**	**NO**	**Explanation of Problem**
EYES (Glaucoma, cataract, retinal disease, loss, etc.)			
DIABETES (list A1C & when diagnosed)			
HEART, CHOLESTEROL, HIGH BLOOD PRESSURE			
BREATHING, LUNGS			
GASTROINTESTINAL			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS			
SKIN			
NEUROLOGICAL / STROKE			
PSYCHIATRIC			
EAR, NOSE, THROAT			
BLOOD / LYMPH			
ALLERGIC / IMMUNOLOGIC			
ENDOCRINE (thyroid)			
OTHER			

Family History

Disease	**YES**	**NO**	**Relationship to Patient**
Blindness			
Cataracts			
Glaucoma			
Macular Degeneration			
Other Eye Disease			
Diabetes			

Social History

	YES	NO	
Do you drive?.....			
Do you have visual difficulty when driving?			If yes: daytime, nighttime, or both?
Do you have visual difficulty when reading?			
Have you ever tried contact lenses?.....			
Do you currently wear contact lenses?.....			If yes: What kind? _____ Solutions used? _____
Are you satisfied with your contacts?.....			
Do you wear glasses?.....			If yes: how old are your current glasses? _____
Do you smoke?.....			If yes: occasional ½ pack/day 1 pack/day 2pack/day 3+ pack/day
Have you ever been a smoker in the past?			For how many years?:_____
Do you drink alcohol?.....			
Are you currently pregnant?.....			If yes: expected due date: _____
Are you currently employed?.....			If yes: occupation? _____

Do you use a computer?..... If yes: how many hours per day? _____

Marital Status: □Single □Divorced □Widowed / Widower □Married / Partnership_____

Spouse / Domestic Partner's Name