Cascade Vision CENTER

PATIENT HISTORY FORM

DATE: _____ PATIENT: _____OCCUPATION:_____

PLEASE LIST ANY EYE DISEASES OR SURGERIES	EYE	DATE OF SURGERY	DOCTOR
	R L		
	R L		
	R L		

LIST ALL MEDICATIONS YOU ARE USING AND THE DOSAGE				PLEASE LIST ANY ALLERGIES TO MEDICATIONS
NAME	DOSAGE	NAME	DOSAGE	

HAVE YOU EVER HAD OR ARE YOU HAVING PROBLEMS IN THESE AREAS ?	NO	YES	IF YES, PLEASE EXPLAIN
EAR, NOSE, THROAT, MOUTH			
HEART, BLOOD PRESSURE, CHOLESTEROL			
URINARY, KIDNEY			
MUSCLES, JOINTS			
HERPES/ZOSTER			
NEUROLOGIC, MIGRAINE, PSYCHIATRIC			
THYROID (GLAND), BLOOD, LYMPHATIC			
IMMUNOLOGIC DISORDER (AIDS-HEPITITIS)			
SINUS, BREATHING, LUNGS			
DIGESTIVE, ABDOMINAL			
DIABETES			
OTHER (I.E. CANCER)			

DO ANY OF YOUR BLOOD RELATIVES HAVE:	NO	YES	IF YES, PLEASE EXPLAIN
GLAUCOMA			
RETINAL DETACHMENTS			
MACULAR DEGENERATION			
STRABISMUS (EYE MUSCLE PROBLEMS)			
CATARACTS			
DIABETES			

PATIENT SIGNATURE:_____ DATE: _____