



Washington Eye Specialists
"Excellence in Eye Care"

History and Intake Form

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____

Address: _____

Phone #: _____

Referring Physician: _____ Ph: _____

Past Medical History: (Please circle all that apply)

Anxiety Arthritis Asthma COPD Coronary Heart Disease
 Depression Diabetes Gerd Hearing Loss Hepatitis Hypertension HIV/AIDS
 Hypercholesterolemia Hyperthyroidism Hypothyroidism Pacemaker
 Radiation Treatment Seizures Strokes

None of the above Other: _____

Past surgical History: (Please circle all that apply)

Bypass Surgery Joint replacement

Others: _____

OCULAR History: (Please circle all that apply) L = Left eye R= Right Eye

Allergic conjunctivitis	L R	Macular Degeneration	L R	Strabismus	L R
Blepharitis	L R	Macular ERM	L R	PVD	L R
Cataract	L R	Narrow Angles	L R	Yag Capsulotomy	L R
Ocular hypertension	L R	Vitreous Floaters	L R		
Corneal Dystrophy	L R	Ophthalmic Migraine	L R		
Diabetic Retinopathy	L R	Pseudoexfoliation	L R		
Dry Eyes	L R	Retinal Tear	L R		
Glaucoma	L R				

OCULAR SURGERY: (Please circle all that apply) L= Left Eye R=Right Eye

	Year			Year			Year	
Blepharoplasty	L	R	LTP	L	R	Trabulectomy	L	R
Cataract Surgery	L	R	PRK	L	R	Tube Shunt	L	R
Corneal transplant	L	R	Ptosis repair	L	R	Yag Capsulotomy	L	R
DSAEK	L	R	Punctal plugs	L	R			
Eye Muscle Surgery	L	R	Strabismus	L	R			
Intravitreal Injection	L	R	Retinal Laser	L	R			
Lasik	L	R	LTP	L	R			
LPI	L	R	PRK	L	R			

Pharmacy:

Name: _____

Phone #: _____ **FAX #:** _____

Address: _____

Store number is available: _____

MEDICATIONS: (please list all current medications)

ALLERGIES: (Please list all allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:

Never Smoked

Quit: former smoker

Smokes daily

Smokes less than 1 pack/day

Alcohol:

Do not drink

Occasional drinks

1-2 Drinks per day

More than 3 drinks/day

Family History: (Please circle all that apply) M=Mother, F=Father, B=Brother, S=Sister

Blindness M F B S Diabetes M F B S Strabismus M F B S

Cancer M F B S Glaucoma M F B S

Cataracts M F B S Heart disease M F B S

CVA M F B S Migraine M F B S

Macular Degeneration M F B S Retinal Detachment M F B S

Are you experiencing any of the following: (Please check Yes or No)

Poor Vision Y N Severe headaches Y N

Eye Pain Y N Anxiety Y N

Redness Y N Uncontrolled Blood pressure Y N

Loss of vision Y N Uncontrolled Blood Sugar Y N