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		