WEST MICHIGAN EYECARE ASSOCIATES, Adult Health History

Name (full legal name): _____ Birth Date: _____ Date: _____
Address (street/city/state/zip): _____
Phone: (cell) _____ (daytime) _____ Email: _____
(email used primarily for appointment reminders)

Ethnicity (please select one): ___ Caucasian ___ African American ___Hispanic or Latino
___ Middle Eastern ___ Asian ___ Hawaiian/Pacific Islander ___Other _____

Race (please select one): ___ White ___ Black or African American ___ Hawiian/Pacific Islander
___ Am. Indian/Alaska native ___Asian ___ Other _____

Height: _____ Weight: _____ Prefer to decline weight: ___

MEDICAL HISTORY

List medications you are currently taking (please include Rx, OTC, vitamins, & eye drops): None

_____

Do you have any allergies to medications? Y N If yes, please explain: _____
List major illnesses, injuries, surgeries, or hospitalizations you have had with approximate dates: None

_____

_____

Name and office location of your medical doctor(s): _____
Date of your last visit: _____

Have you ever been treated for any of the following medical conditions?

			Comments
High Blood Pressure	Y	N	_____
Heart Disease or Problems	Y	N	_____
Allergy or Hay Fever	Y	N	_____
Asthma or Lung Disease	Y	N	_____
Diabetes	Y	N	_____
Thyroid Disease	Y	N	_____
Arthritis	Y	N	_____
Cancer	Y	N	_____

FAMILY HISTORY

			Relationship
Blindness	Y	N	_____
Glaucoma	Y	N	_____
Macular Degeneration	Y	N	_____
Cataracts	Y	N	_____
Diabetes	Y	N	_____
High Blood Pressure	Y	N	_____
Cancer	Y	N	_____
Heart Disease	Y	N	_____
Other	Y	N	_____

OCULAR HISTORY

Please list any past or present eye diseases, eye infections, or eye surgeries you have had. None

_____

_____

Do you wear glasses? YES NO
Do you wear sunglasses? YES NO
Do you wear contact lenses? YES NO If yes, what type: _____

Turn Over

PERSONAL INFORMATION

What is your occupation? _____ Marital Status: _____

List your hobbies/recreational activities: _____

Do your occupation or any hobbies/recreational activities require the use of safety eyewear? Y N

Do you use the computer at work or at home?	Y	N	Do you drink alcohol?	Y	N
Do you drive?	Y	N	If yes, how often? _____		
If yes, do you have visual difficulty when driving?	Y	N	Do you use illegal drugs?	Y	N
Do you use tobacco products?	Y	N	Have you ever been exposed to HIV?	Y	N
If yes, what type/amount/how long? _____			Have you ever been exposed to TB?	Y	N

REVIEW OF SYSTEMS *Do you currently have any of the following?*

CONDITION	YES	NO	IF YES, PLEASE EXPLAIN:
Eye System			
Eye injury, pain, or surgery			
Loss of vision			
Blurred vision			
Tired eyes			
Redness			
Itching			
Burning			
Sandy or dry eyes			
Excessive tears (watery eyes)			
Vision disturbance (spots, halos, light flashes)			
Light sensitivity / glare			
Double vision			
Glaucoma			
Cataract			
Macular degeneration			
Diabetic retinopathy			
Amblyopia (lazy eye)			
Strabismus (crossed eyes)			
Keratoconus (disease of cornea)			
Learning disability			
Constitutional (fever, weight loss, etc.)			
Ears, Nose, Mouth, Throat (sinus, chronic cough, etc.)			
Respiratory (asthma, emphysema, etc.)			
Cardiovascular (high blood pressure, Vascular disease, etc.)			
Gastrointestinal (diarrhea, constipation, ulcers, etc)			
Genitourinary (genitals, kidney, bladder)			
Muscles/Bones/Joints (arthritis, etc.)			
Endocrine (diabetes, thyroid, etc.)			
Psychiatric (anxiety, depression, etc.)			
Blood/Lymph (anemia, high cholesterol)			
Allergic/Immunologic (hay fever, lupus)			
Skin (rashes, measles, chicken pox, etc.)			
Neurological (headaches, multiple sclerosis, etc.)			

Thank you.