NWEC
NORTHWEST EYE CLINIC

Patient Name: ______________________________

Date of Birth: ______________________________

Today's Date: ______________________________

Primary Care Physician: ______________________________

Pharmacy: ______________________________

Previous eye conditions:	Eye Medications:	Eye Surgeries:	Dates:

Medications - Prescription & Over the Counter: ☐ See List		Drug Allergies: ☐ See List	Reaction:
		☐ No Known Drug Allerges	

Past Medical History: Please Circle	
Diabetes Year Diagnosed: ___________	Epilepsy, seizures
High blood pressure	Migraine headaches
Heart disease, heart attack, arrhythmia, pacemaker	Acid reflux, gastric ulcers
Cancer Type: ____________________	High cholesterol, stroke, TIA
Asthma, emphysema, COPD, other lung disease	Blood clots
Sleep apnea	Hypothyroidism, hyperthyroidism (Graves)
Degenerative arthritis, rheumatoid arthritis	Anxiety, depression, PTSD, bipolar disorder
Kidney stones, dialysis, other kidney disease	Autoimmune disease
Anemia, other blood disorder	Pneumonia
Gallbladder disease	Polio, meningitis
MRSA infection, tuberculosis, HIV, chronic infection	Sexually transmitted disease
Bladder infection, other bladder problems	Jaundice, liver disease
Eczema, rosacea, other skin problems	Seasonal allergies, allergic rhinitis

Previous Surgery with Dates:	

Family History - have any blood relatives had:			If yes, who?
Macular degeneration	No ☐	Yes ☐	
Glaucoma	No ☐	Yes ☐	
Retinal detachment	No ☐	Yes ☐	
Lazy eye	No ☐	Yes ☐	
Cataracts at an early age	No ☐	Yes ☐	

Social History:

Tobacco Use? Yes ☐ No ☐

If yes, how much per day? ______________________________

For how many years? ______________________________

When did you quit? ______________________________

Marital Status:

☐ Single ☐ Married/Partnered ☐ Widowed

Occupation: ______________________________

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How are you feeling today? Please circle any that apply:

Review of Systems:	**Please Circle:**
General:	Chills, fever, abnormal weight gain or loss, abnormal fatigue
Skin:	Rash, dry skin, skin lesions
Ear/Nose/Throat:	Chronic ear infections, sinus congestion, sore throat
Cardiovascular:	Chest pain, palpitations, leg swelling
Respiratory:	Shortness of breath, coughing, wheezing
Gastrointestinal:	Nausea, vomiting, diarrhea, constipation, heartburn
Genitourinary:	Frequent urination, burning with urination
Musculoskeletal:	Muscle pain, joint pain, back pain
Neurological:	Memory loss, loss of balance, headaches, fainting, dizziness
Psychiatric:	Depression, anxiety
Endocrine:	Intolerance to heat or cold
Hemato/Lymph:	Increased bruising, delay in healing after a cut
Immunologic:	Seasonal allergies, hives

MD/OD Signature: ________________________________