OREGON TRAIL EYE CENTER, PC

Patient Name: **DOB:**

Past Medical History

*Are you or have **ever** you been treated for:*

Diabetes	Y	N
High Blood Pressure	Y	N
Heart Disease (MI, irregular beat)	Y	N
Lung Disease (Asthma, COPD)	Y	N
GI/Colitis/Liver Disease	Y	N
Neuro Disease/Stroke	Y	N
Vascular Disease	Y	N
Arthritis	Y	N
Cancer	Y	N
Bleeding Disorder/Anemia	Y	N
HIV/AIDS/STD	Y	N
Kidney Disease/Dialysis	Y	N
Thyroid Disease	Y	N
High Cholesterol	Y	N

Past Surgical History:

Please list all past surgeries and/or injuries:

Oral Medications, including vitamins

Please list all medications; name, dosage, frequency:

(Use separate sheet of paper if needed)

Food, Drug, Other Allergies: *(Use separate sheet of paper if needed)*

Eye Disease/Surgery

Do you have or have you been treated for:

Retinopathy (Diabetes, Hypertension)	Y	N
Macular Degeneration	Y	N
Macular Edema	Y	N
Macular Hole	Y	N
Retinal Vein Occusion	Y	N
Vitreous Floaters	Y	N
Vitreous Hemorrhage	Y	N
Retinal Tear	Y	N
Retinal Detachment	Y	N
Cataract	Y	N
Glaucoma	Y	N
Infection	Y	N
Inflammation	Y	N
Strabismus/Amblyopia	Y	N
Dry Eyes	Y	N
Corneal Disease	Y	N

Other:_____

If yes, please explain (treatment, duration, surgery):

Eye Medications - *Please list name, dosage, frequency:*

(Use separate sheet of paper if needed)

Family and Social History - Do **any** medical or eye diseases run in your family? If Yes, please list & explain:

History of Tobacco use? Y N Type?_____ How Much? _____ Age quit?_____

Did you have the Influenza Vaccine this flu season (October 1st - March 31st)? Y N

Have you (in your lifetime) had pneumococcal vaccine? Y N

Have you had two or more falls in past year or any fall with injury in the past year? Y N

Clear & Reset Form

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