Bellingham Bay Ophthalmology, PLLC
Patient History Form

Patient Name: _____ **Date of Birth:** _____

Medical History: ☐ NONE (Unknown)

Cardiovascular:

❑ Angina

❑ Heart Attack

❑ Pacemaker

❑ High Cholesterol

❑ High Blood Pressure

Pulmonary:

❑ COPD

❑ Asthma

❑ Shortness of Breath

❑ TB

Dermatology:

❑ Rosacea

❑ Rash

❑ Lump

Gastrointestinal:

❑ Reflux

Genitourinary:

❑ Enlarged Prostate

❑ Increase Frequency

❑ Frequent UTI

❑ Kidney Stones

Endocrine:

Neurological:

❑ Alzheimer's

❑ Epilepsy

❑ Migraines/Headaches

❑ Multiple Sclerosis

❑ Neuropathy

❑ Parkinson's

❑ Seizures

❑ Stroke

❑ TIA

❑ Tremor

Psychiatric:

❑ Depression

❑ Bipolar

❑ Schizophrenia

❑ Anxiety

Hematologic:

❑ Anemia/Excessive Bleeding

❑ Cancer: _____

Musculoskeletal:

❑ Arthritis

❑ Rheumatoid Arthritis

❑ Gout

❑ Diabetes – HA1C? _____

❑ Thyroid Disease

 TURN OVER

Patient Name: _____ Date of Birth: _____

Surgical Eye History: ☐ NONE **Allergies to Medications:** ☐ NONE

Name Of Surgery / Date	Medication

Medications Currently Taking: ☐ See attached list provided ☐ NONE

Name of Medication	Name of Medication

Social History:

Tobacco Use: ☐ Current ☐ Past Smoker ☐ Never

Alcohol Use: ☐ None ☐ Less than 1 drink daily ☐ 1-2 drinks daily ☐ 3 or more drinks daily

Family History: Any blood relative with the following ☐ Adopted (unknown history) ☐ NONE

Amblyopia (crossed or lazy eye):
☐ Parent ☐ Sibling ☐ Child ☐ Other – who? _____

Glaucoma:
☐ Parent ☐ Sibling ☐ Child ☐ Other – who? _____

Retinal Disease or Retinal Detachment:
☐ Parent ☐ Sibling ☐ Child ☐ Other – who? _____

Strabismus (misalignment of eyes):
☐ Parent ☐ Sibling ☐ Child ☐ Other – who? _____

Diabetes:
☐ Parent ☐ Sibling ☐ Child ☐ Other – who? _____

Macular Degeneration:
☐ Parent ☐ Sibling ☐ Child ☐ Other – who? _____

Unexplained Vision Loss:

☐ Parent ☐ Sibling ☐ Child ☐ Other – who? _____