## Tacoma Eye Health Questionnaire Please complete both sides of this questionnaire

Patient Name:  Reason for today's visit (circle one) I need eyeglasses I need contact lenses I want a check up. Other(write below):  Have you ever been diagnosed with any of the following eye conditions? (Circle if yes)  Macular Degeneration Glaucoma Diabetic Retinopathy Dry Eye Iritis/Uveitis Retinal defects or degenerations  Family Medical History Please CIRCLE if family members have: Cancer Diabetes  High Blood pressure. Thyroid problems  What medication allergies do you have?  What medications are you currently taking? (prescription and over-the counter)  What medications are you currently taking? (prescription and over-the counter)		
I need eyeglasses I need contact lenses    Want a check up. Other(write below):   Please list any other provider caring for you	Patient Name:	Date of Birth:
I need eyeglasses I need contact lenses    Want a check up. Other(write below):   Please list any other provider caring for you	December today/a visit (sixela ena)	Who is your Drimon, save provider (DCD)?
Please list any other provider caring for you  Have you ever been diagnosed with any of the following eye conditions? (Circle if yes)  Macular Degeneration  Glaucoma  Diabetic Retinopathy  Dry Eye  Iritis/Uveitis  Retinal defects or degenerations  Family Medical History  Please CIRCLE if family members have:  Cancer  Diabetes  Cataracts  High Blood pressure. Thyroid problems  What medication allergies do you have?  Please Iist any other provider caring for you  Do you have any eye/vision concerns today? (Circle if yes)  Redness  Burning  Itching  Blurred vision/Eyestrain  Family Ocular History  Please CIRCLE if family members have:  Cataracts  Macular degeneration  Glaucoma  PFSH Tobacco Smoking Status (Circle one)  I smoke  I quit smoking  I don't smoke	Reason for today's visit (circle one)	who is your Primary care provider (PCP)?
Have you ever been diagnosed with any of the following eye conditions? (Circle if yes)  Macular Degeneration Glaucoma Diabetic Retinopathy Dry Eye Iritis/Uveitis Retinal defects or degenerations  Family Medical History Please CIRCLE if family members have:  Cancer Diabetes High Blood pressure. Thyroid problems  What medication allergies do you have?  What medications are you currently taking?  Do you have any eye/vision concerns today? (Circle if yes)  Redness Burning Burning Burring Blurred vision/Eyestrain  Family Ocular History Please CIRCLE if family members have: Cataracts  Macular degeneration Glaucoma  FFSH Tobacco Smoking Status (Circle one) I smoke I quit smoking I don't smoke	I need eyeglasses I need contact lenses	
following eye conditions? (Circle if yes)  Macular Degeneration  Glaucoma  Burning  Diabetic Retinopathy  Dry Eye  Iritis/Uveitis  Retinal defects or degenerations  Family Medical History  Please CIRCLE if family members have:  Cancer Diabetes  Cataracts  High Blood pressure. Thyroid problems  What medication allergies do you have?  What medications are you currently taking?  (Circle if yes)  Redness  Burning  Itching  Family Ocular History  Please CIRCLE if family members have:  Cataracts  Macular degeneration  Glaucoma  I smoke I quit smoking I don't smoke	I want a check up. Other(write below):	Please list any other provider caring for you
following eye conditions? (Circle if yes)  Macular Degeneration  Glaucoma  Burning  Diabetic Retinopathy  Dry Eye  Iritis/Uveitis  Retinal defects or degenerations  Family Medical History  Please CIRCLE if family members have:  Cancer Diabetes  Cataracts  High Blood pressure. Thyroid problems  What medication allergies do you have?  What medications are you currently taking?  (Circle if yes)  Redness  Burning  Itching  Family Ocular History  Please CIRCLE if family members have:  Cataracts  Macular degeneration  Glaucoma  I smoke I quit smoking I don't smoke		
Glaucoma Diabetic Retinopathy Dry Eye Tearing Blurred vision/Eyestrain  Retinal defects or degenerations  Family Medical History Please CIRCLE if family members have: Cancer Diabetes Cataracts High Blood pressure. Thyroid problems  What medication allergies do you have?  What medications are you currently taking?		
Diabetic Retinopathy Dry Eye Tearing Blurred vision/Eyestrain  Retinal defects or degenerations  Family Medical History Please CIRCLE if family members have: Cancer Diabetes Cancer Diabetes High Blood pressure. Thyroid problems  Macular degeneration Glaucoma  What medication allergies do you have?  PFSH Tobacco Smoking Status (Circle one)  I smoke I quit smoking I don't smoke	Macular Degeneration	Redness
Dry Eye Tearing Blurred vision/Eyestrain  Retinal defects or degenerations  Family Medical History Please CIRCLE if family members have:  Cancer Diabetes Cataracts High Blood pressure. Thyroid problems  What medication allergies do you have?  Presh Tobacco Smoking Status (Circle one)  I smoke I quit smoking I don't smoke  What medications are you currently taking?	Glaucoma	Burning
Iritis/Uveitis  Retinal defects or degenerations  Family Medical History Please CIRCLE if family members have:  Cancer Diabetes  High Blood pressure. Thyroid problems  What medication allergies do you have?  Pease CIRCLE if family members have:  Cataracts  Macular degeneration  Glaucoma  PFSH Tobacco Smoking Status (Circle one)  I smoke I quit smoking I don't smoke  What medications are you currently taking?	Diabetic Retinopathy	Itching
Retinal defects or degenerations  Family Medical History Please CIRCLE if family members have:  Cancer Diabetes  High Blood pressure. Thyroid problems  What medication allergies do you have?  Please CIRCLE if family members have:  Cataracts  Macular degeneration  Glaucoma  PFSH Tobacco Smoking Status (Circle one)  I smoke I quit smoking I don't smoke	Dry Eye	Tearing
Family Medical History Please CIRCLE if family members have:  Cancer Diabetes  High Blood pressure. Thyroid problems  What medication allergies do you have?  Family Ocular History Please CIRCLE if family members have:  Cataracts  Macular degeneration  Glaucoma  PFSH Tobacco Smoking Status (Circle one)  I smoke I quit smoking I don't smoke  What medications are you currently taking?	Iritis/Uveitis	Blurred vision/Eyestrain
Please CIRCLE if family members have:  Cancer Diabetes Cataracts  High Blood pressure. Thyroid problems Macular degeneration Glaucoma  What medication allergies do you have?  Please CIRCLE if family members have:  Cataracts  Macular degeneration  Glaucoma  PFSH Tobacco Smoking Status (Circle one)  I smoke I quit smoking I don't smoke  What medications are you currently taking?	Retinal defects or degenerations	
Cancer Diabetes Cataracts  High Blood pressure. Thyroid problems Macular degeneration  Glaucoma  What medication allergies do you have?  PFSH Tobacco Smoking Status (Circle one)  I smoke I quit smoking I don't smoke  What medications are you currently taking?	Family Medical History	Family Ocular History
High Blood pressure. Thyroid problems  Glaucoma  What medication allergies do you have?  PFSH Tobacco Smoking Status (Circle one)  I smoke  I quit smoking  I don't smoke  What medications are you currently taking?	Please CIRCLE if family members have:	Please CIRCLE if family members have:
What medication allergies do you have?  PFSH Tobacco Smoking Status (Circle one)  I smoke I quit smoking I don't smoke  What medications are you currently taking?	Cancer Diabetes	Cataracts
What medication allergies do you have?  PFSH Tobacco Smoking Status (Circle one)  I smoke I quit smoking I don't smoke  What medications are you currently taking?	High Blood pressure. Thyroid problems	Macular degeneration
(Circle one)  I smoke I quit smoking I don't smoke  What medications are you currently taking?		Glaucoma
What medications are you currently taking?	What medication allergies do you have?	
What medications are you currently taking?  (prescription and over-the counter)		I smoke I quit smoking I don't smoke
	What medications are you currently taking? (prescription and over-the counter)	

Tacoma Eye Health Questionnaire
Please complete both sides of this questionnaire

Review Of Systems  Have you been treated for any of the following?	Review of Systems  Have you been treated for any of the following?
CONSTITUTIONAL  Developmental Issues	
Cancer	GI Crohn's Dz
Fatigue syndrome	Colitis
ENT Hearing loss	<b>GU</b> Kidney Dz
Sinusitis	STD
Dry Mouth	Pregnant or Nursing
NEUROLOGIC  Multiple Sclerosis	MUSC/SKEL Arthritis
Epilepsy	Fibromyalgia
Autism SD	Ankylosing Spondylitis
PSYCHIATRIC Depression	INTEGUMENTARY  Eczema
ADHD	Acnes Rosacea
Anxiety'Bipolar	Shingles
CARDIOVASCULAR	ENDOCRINE
High Blood pressure	Diabetes Type 1 or Type 2
Stroke	Thyroid dysfunction
Heart disease  RESPIRATORY  Asthma	H&L  Anemia  High cholesterol
COPD Sleep Apnea	IMMUNE Lupus
	Sjogren's Syndrome  Other items not covered that you would like us to know about?
I attest this form was is completed by the signee to their best recollection and ability.	Signed:
	Date: