HILLSBORO EYE CLINIC, P.C.

HillsboroEyeClinic.com | 503-640-3708

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MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No

If YES please list the medications: _____

_____

HAVE YOU HAD ANY SURGERIES? ☐ Yes ☐ No

If YES please list all operations (cataract, appendectomy etc.): _____

_____

PATIENT – MEDICAL HISTORY

YES	NO		YES	NO		YES	NO	
☐	☐	Allergies	☐	☐	Heart Disease	☐	☐	Seizure Disorder
☐	☐	Asthma	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease
☐	☐	Arthritis	☐	☐	High Cholesterol	Other:		
☐	☐	Depression	☐	☐	Kidney Disease			
☐	☐	Diabetes ☐ Type 1 or ☐ Type 2	☐	☐	Liver Disease			
			☐	☐	Migraine			
☐	☐	GERD	☐	☐	Osteoporosis			

FAMILY – PAST MEDICAL HISTORY

YES	NO		YES	NO		YES	NO	
☐	☐	Asthma	☐	☐	Kidney Disease	☐	☐	Macular Degeneration
☐	☐	Cardiovascular Disease	☐	☐	Migraines	☐	☐	Glaucoma
☐	☐	Depression	☐	☐	High Blood Pressure	☐	☐	Cataracts
☐	☐	Diabetes ☐ Type 1 or ☐ Type 2	☐	☐	Osteoporosis	Other:		
☐	☐	Cancer: Type_____	☐	☐	Seizure Disorder			
			☐	☐	Stroke			
			☐	☐	Thyroid Disease			

SOCIAL

Current Employer/Student: _____ ☐ Minor

Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married / Spouse Name:_____

YES	NO	
☐	☐	Do you drive?
☐	☐	Do you have visual difficulty when driving?
☐	☐	Do you have problems with night vision?
☐	☐	Do you drink alcohol? If yes: ☐ 1/day ☐ 2-3/day ☐ 4+/day ☐ Occasional

YES	NO	
☐	☐	Do you smoke? Type _____
☐	☐	Are you a previous smoker? How long did you smoke?_____ When did you quit? _____ How much did you smoke?_____
☐	☐	Were you exposed to passive smoke?