HILLSBORO EYE CLINIC, P.C.

HillsboroEyeClinic.com | 503-640-3708

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MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____

Other Care Physician: _____ Specialty: _____

CURRENT MEDICATION? (or copy of list)

_____

_____

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	
☐	☐	Allergies
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Autoimmune/ Rheumatologic Disease
☐	☐	Diabetes ☐ Type 1 or ☐ Type 2
☐	☐	Cancer: Type:
☐	☐	Glaucoma
☐	☐	Heart Disease/High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Liver Disease
☐	☐	Macular Degeneration
☐	☐	Migraine
☐	☐	Multiple Sclerosis
☐	☐	Thyroid Disease

Other:

_____

PATIENT – SOCIAL HISTORY

YES	NO	
☐	☐	Do you smoke?
☐	☐	Are you a previous smoker? What year did you quit?
☐	☐	Do you use recreational drugs?

PATIENT – PRIOR EYE SURGERIES

YES	NO	
☐	☐	Cataract ☐ Left eye ☐ Right eye
☐	☐	Lasik Year?
☐	☐	PRK Year?
☐	☐	Retinal Surgery

FAMILY – MEDICAL HISTORY

YES	NO	
☐	☐	Glaucoma
☐	☐	Macular Degeneration

Other Eye Diseases:

_____