BelleVue
SPECIALTY EYE CARE

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FAMILY AND SOCIAL HISTORY

Today's Date: ________/________/________

Name:____ Date of Birth: ________/________/________

Health History Update

Since your last visit, have you had any NEW visual or medical problems, surgeries or hospitalizations? (Include year)

☐ None

____
____
____
____

Medications currently taking and for what condition:

☐ None

____
____
____
____

Allergies:

☐ None ☐ Drug ☐ Environmental

____
____
____
____

Primary Care Physician _________________________

Eye Care Physician ____________________________

Last Eye Exam: ________/________/________

Currently wear: ☐ Glasses ☐ Contacts

Have had Eye Surgery in the past: ☐ Yes ☐ No

Social History

Marital Status:

☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed

Employment Status:

☐ Working Occupation: ______________________
☐ Unemployed ☐ Retired ☐ Disabled

Patient and Family History

List **you** and/or family member and age diagnosed

Amblyopia (lazy eye) ____________________
Asthma ____________________
Cancer ____________________
Color Deficiency ____________________
Diabetes ____________________
Double Vision ____________________
Glaucoma ____________________
Headaches/Migraines ____________________
Heart Disease ____________________
High Blood Pressure ____________________
High Cholesterol ____________________
Learning Problems ____________________
Macular Degeneration ____________________
Mental Illness (specify) ____________________
Multiple Sclerosis ____________________
Osteoporosis ____________________
Retinal disease ____________________
Retinitis Pigmentosa ____________________
Strabismus (crossed eye) ____________________
Stroke ____________________
Tuberculosis ____________________
Thyroid Condition ____________________

Risk Factors

Tobacco: ☐ Never
☐ Passive Smoke Exposure ☐ Current ☐ Past
☐ Cigarettes: ____ #/day ☐ Cigars: ____ #/week
☐ Chew: ____ cans/day ☐ Pipe

Alcohol: ☐ Yes ☐ No
Type: ________________ drinks ____ /day

Recreational Drugs: ☐ Yes ☐ No
Type: ______________________

REVIEW OF SYSTEMS

Problems you had in the past/are currently experiencing: ☐ None

Constitutional	Past	Present
Developmental Disabilities	☐	☐
Cancer	☐	☐
Fatigue Syndrome	☐	☐

ENT	Past	Present
Hearing Loss	☐	☐
Sinusitis	☐	☐
Dry Mouth	☐	☐
Laryngitis	☐	☐

Integumentary	Past	Present
Eczema	☐	☐
Rosacea	☐	☐
Shingles	☐	☐

Neurological	Past	Present
Headaches	☐	☐
Migraine	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy/Seizures	☐	☐
Cerebral Palsy	☐	☐
Tumor	☐	☐
Stroke/CVA	☐	☐
Autism	☐	☐
Concussion	☐	☐

Respiratory	Past	Present
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Sleep Apnea	☐	☐

Eyes	Past	Present
Itching	☐	☐
Burning	☐	☐
Redness	☐	☐
Dryness	☐	☐
Tired Eyes	☐	☐
Mucous Discharge	☐	☐
Sandy/Gritty Feeling	☐	☐
Sties/Chalazion	☐	☐
Blurred Vision	☐	☐
Double Vision	☐	☐
Loss of Vision	☐	☐
Loss of Side Vision	☐	☐
Distorted Vision/Halos	☐	☐
Eye Pain or Soreness	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Chronic Infection of Eye Lid	☐	☐
Flashes/Floaters in Vision	☐	☐
Foreign Body Sensation	☐	☐

Vascular/Cardiovascular	Past	Present
Heart Disease	☐	☐
High Blood Pressure	☐	☐
Stroke	☐	☐
Vascular Disease	☐	☐
Congestive Heart Failure	☐	☐

Gastrointestinal	Past	Present
Crohn’s	☐	☐
Colitis	☐	☐
Ulcer	☐	☐
Acid Reflux	☐	☐
Celiac Disease	☐	☐

Genitourinary	Past	Present
Prostate Disease/Cancer	☐	☐
Kidney Disease	☐	☐
Bladder	☐	☐
STD - Herpes, Chlamydia	☐	☐
STD - Other	☐	☐

Bones/Joints/Muscles	Past	Present
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Fibromyalgia	☐	☐
Gout	☐	☐

Hemotologic/Lymphatic	Past	Present
Anemia	☐	☐
Ulcer	☐	☐
High Cholesterol	☐	☐
HIV/AIDS	☐	☐

Endocrine	Past	Present
Thyroid	☐	☐
Diabetes Type 1	☐	☐
Diabetes Type 2	☐	☐
Hormonal Dysfunction	☐	☐

Allergic/Immunologic	Past	Present
Drug Allergies	☐	☐
Environmental Allergies	☐	☐
Rheumatoid Arthritis	☐	☐
Sjogren’s Syndrome	☐	☐
Lupus	☐	☐

Psychiatric	Past	Present
Depression	☐	☐
Attention Deficit (ADD/ADHD)	☐	☐
Anxiety Disorder	☐	☐
Bipolar	☐	☐

PATIENT OR PARENT/GUARDIAN SIGNATURE: ______________________________