GLENWOOD
FAMILY EYE CENTER
GLACIAL RIDGE HEALTH SYSTEM

BRIEF HISTORY

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last Name: First Name: Sex: M F

Date of Birth: Age: Occupation:

Provider Notes
Please do not write in this area.

ILLNESS/INJURY: Please check if you have ever had:

Yes	No		Yes	No	
		High blood pressure			Iritis
		Diabetes			Diabetic Retinopathy
		Cataracts			Wear Contact Lenses
		Glaucoma			Allergies
		Macular Degeneration			Other:
		Detached Retina			
		Near Sighted			
		Far Sighted			
		Astigmatism			
		Cornea Abnormalities			
		Pupil Abnormalities			

OPERATIONS: List names and dates of all operations you have had None

Year	Name of Operation	Type of Anesthetic, if known	Complications

FAMILY HISTORY:

Do you have a family history of:
Diabetes? Yes No Macular Degeneration? Yes No
Glaucoma? Yes No High Blood Pressure? Yes No

Current Medications:____
List any eye drops currently using:____

Do you currently use tobacco? Yes No Years of use __________
Have you ever used tobacco? Yes No Quit date _____________

Do you currently use alcohol? Yes No Number of drinks per week _____________
Have you ever abused alcohol? Yes No Quit date _____________

Are you allergic to any medicine?

Other allergies?

Provider Initials

____

The above information is true and accurate
Patient Signature (parent if patient is a minor)______________________________________
Date:_________________________

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Patients Name:	Chart #
Pre-test/Vitals:	
Height:___________ Weight:___________ BP:___________ BS:___________	
ILLNESS/INJURY: Please check if you have ever had:	

Y	N	*Allergic:*	Y	N	*Eyes:*	Y	N	*Musculoskeletal*	Y	N	*Cardiovascular*
		Drug Allergy			Glaucoma			Fibromyalgia			Heart Disease
		Environmental Allergy			Cataracts			Muscular Dystrophy			Hypertension (High BP)
		Rheumatoid Arthritis			M.D. (AMD)			Osteoarthritis			Stroke
		Lupus			Surgery			Ankylosing Spondylitis			Vascular Disease
		Other:			Blurred Vision			Other:			Other:
					Double Vision						
					Other:						
Y	N	*Gastrointestinal:*	Y	N	*Neurological:*	Y	N	*Constitutional:*	Y	N	*Genitourinary:*
		Crohn's			MS			Developmental Disability			STD
		Colitis			Epilepsy			Weight Loss			☐ Viral
		Ulcer			Alzheimer's			Fever			☐ Hepatic
		Digestive			Parkinson's			Fatigue			☐ Chlamydia
		Other:			Cerebrovascular			Trauma			Other:
					Other:			Other:			
Y	N	*Psychiatric:*	Y	N	*Ear/Nose/Throat:*	Y	N	*Hematologic:*	Y	N	*Respiratory:*
		Depression			Upper Respiratory Infection			Anemia			Asthma
		Panic Disorder			Ear Ache			Large Volume Blood Loss			Bronchitis
		Schizophrenia			Runny Nose			Leukemia			Emphysema
		Other:			Sore Throat			Other:			Sore Throat
					Ringing/Tinnitus						Other:
					Other:						Smoking Status
											☐ Current
											☐ Former
											☐ Never
Y	N	*Endocrine:*	Y	N	*Integumentary:*						
		Non-insulin Dependent Diabetes			Eczema						
		Insulin Dependent			Rosacea						
		Thyroid Dysfunction			Psoriasis						
		Hormonal Dysfunction			Other:						
		Other:									