IDAHO EYE and LASER CENTER

PATIENT HEALTH HISTORY

REFERRED BY: ______________________________

DATE: ____________________________________

PATIENT
NAME: LAST FIRST DOB

HEIGHT: WEIGHT: PRIMARY CARE PHYSCIAN:

Primary Language: ☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Arabic ☐ Other ___________________

PLEASE LIST ALL MEDICATIONS, INCLUDING EYE DROPS, YOU TAKE ON A REGULAR BASIS

☐ I AM NOT TAKING ANY MEDICATIONS **PREFERRED PHARMACY/LOCATION**: ________________________________

MEDICATION	DOSE / FREQUENCY	MEDICATION	DOSE/FREQUENCY

DO YOU HAVE ANY ALLERGIES ☐ NO ☐ YES If yes please list:

ALLERGY	REACTION	ALLERGY	REACTION

MEDICAL HISTORY: *PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS.*

☐ ASTHMA/LUNG DISEASE ☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE ☐ HIGH CHOLESTEROL ☐ ALZHEIMER'S
☐ KIDNEY DISEASE ☐ THYROID DISEASE ☐ ARTHRITIS ☐ CANCER (specify) _________________ ☐ SLEEP APNEA
☐ DIABETES (when diagnosed?):________ ☐ TYPE I ☐ TYPE II ☐ Current Insulin Use
☐ MRSA ☐ HEPATITIS_____ ☐ HIV/AIDS ☐ TUBERCULOSIS ☐ LIVER DISEASE ☐ HEARING AIDS ☐ DENTURES
☐ ANXIETY/DEPRESSION ☐ LUPUS ☐ SJOGREN'S ☐ STROKE ☐ SEIZURE ☐ OTHER: ______________________________

SURGICAL HISTORY: *PLEASE LIST ALL SURGERIES YOU HAVE HAD INCLUDING DATES*.

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REVIEW OF SYMPTOMS: PLEASE CHECK ANY ***CURRENT*** SYMPTOMS YOU ARE EXPERIENCING TODAY

CARDIOVASCULAR

- ☐ CHEST PAIN
- ☐ IRREGULAR HEARTBEAT
- ☐ SHORTNESS OF BREATH

ENT

- ☐ DIZZINESS
- ☐ HEARING LOSS
- ☐ SORE THROAT

MUSCULOSKELETAL

- ☐ BACK PAIN
- ☐ JOINT PAIN
- ☐ MUSCLE ACHES

RESPIRATORY

- ☐ COUGH
- ☐ WHEEZING
- ☐ TROUBLE BREATHING

CONSTITUTIONAL

- ☐ FATIGUE/WEAKNESS
- ☐ FEVER
- ☐ WEIGHT LOSS

HEMATOLOGIC

- ☐ BLEED EASILY
- ☐ BRUISING

NEUROLOGICAL

- ☐ NUMBNESS
- ☐ HEADACHE
- ☐ TINGLING

SKIN

- ☐ HAIR LOSS
- ☐ RASH
- ☐ SKIN LESIONS

GENITOURINARY

- ☐ GENITAL DISCHARGE
- ☐ GENITAL LESIONS
- ☐ PAINFUL URINATION
- ☐ URGENCY

PSYCHIATRIC

- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ INSOMNIA
- ☐ IRRITABILITY

ALLERGY

- ☐ ITCHING
- ☐ HIVES
- ☐ SEASONAL

METABOLIC

- ☐ COLD INTOLERANCE
- ☐ EXCESS HUNGER
- ☐ EXCESS THIRST
- ☐ FREQUENT URINATION

HIGH / LOW BLOOD PRESSURE

- ☐ GOOD CONTROL
- ☐ BORDERLINE CONTROL
- ☐ POOR CONTROL
- ☐ UNKNOWN CONTROL

DIABETES CONTROL

- ☐ NOT APPLICABLE
- ☐ GOOD CONTROL
- ☐ BORDERLINE CONTROL
- ☐ POOR CONTROL
- ☐ UNKNOWN CONTROL
- ☐ CURRENT INSULIN USE

PREGNANCY

- ☐ NOT APPLICABLE
- ☐ NOT PREGNANT
- ☐ 1st TRIMESTER
- ☐ 2nd TRIMESTER
- ☐ 3rd TRIMESTER

OTHER:____

SOCIAL HISTORY:

ALCOHOL USE: ☐ NEVER ☐ RARELY ☐ OCCASIONALLY ☐ DAILY ☐ FREQUENT

TOBACCO USE: ☐ NEVER ☐ OCCASIONALLY ☐ DAILY ☐ FORMER SMOKER

FAMILY HISTORY

DISEASE	YES	NO	RELATIONSHIP
BLINDNESS			
GLAUCOMA			
MACULAR DEGENERATION			
HEART DISEASE			
CANCER			
HIGH BLOOD PRESSURE			
STROKE			
DIABETES			
OTHER			

SIGNATURE:_________________________________

OFFICE REVIEWED:_________________________________

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