IDAHO EYE and LASER CENTER

PATIENT HEALTH HISTORY

DATE: _____

PATIENT
NAME: LAST FIRST

DOB: _____ **HEIGHT:** _____ **WEIGHT:** _____

PRIMARY LANGUAGE: □ English □ Spanish □ French □ Chinese □ Arabic □ Other _____

PREFERRED PHARMACY/LOCATION: _____

PRIMARY CARE PHYSICIAN: _____

OPTOMETRIST: _____

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

□ I AM NOT TAKING ANY MEDICATIONS

MEDICATION	DOSE / FREQUENCY	MEDICATION	DOSE/FREQUENCY

DO YOU HAVE ANY ALLERGIES? **□ NO** **□YES** If yes please list:

ALLERGY	REACTION	ALLERGY	REACTION

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

_____

_____

_____

_____

_____

PLEASE TURN PAGE OVER, COMPLETE, SIGN AND DATE

MEDICAL HISTORY:
PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS BY CIRCLING YES [Y] or NO [N].

Lung Disease	Y / N	Heart Disease	Y / N	Gastro-intestinal	Y / N	Neuro-Disease	Y / N	Steroid Use	Y / N
Sleep Apnea	Y / N	Hypertension	Y / N	Renal Disease	Y / N	Bleeding Tendency	Y / N	Anesthesia Complications	Y / N
Current Infection	Y / N	Seizure	Y / N	Liver Disease	Y / N	Blood thinners	Y / N	Auto-Immune Disease	Y / N
Cough	Y / N	Stroke	Y / N	Cancer: Type _____	Y / N	Recent Chest pain	Y / N	Hearing Aide	Y / N
Asthma	Y / N	High Cholesterol	Y / N	Alzheimers	Y / N	Thyroid Disease	Y / N	Arthritis	Y / N
Lupus	Y / N	MRSA	Y / N	Hepatitis Type _____	Y / N	HIV/AIDS	Y / N	Tuberculosis	Y / N
Sjogren's	Y / N	Muscle/Joint Disorder	Y / N	Dentures	Y / N	Anxiety	Y / N	Depression	Y / N
Pre-Diabetic	Y / N	Diabetes Type I	Y / N	Diabetes Type II	Y / N	Insulin Resistance	Y / N	Other: _____	Y / N

PREGNANCY: □ NOT APPLICABLE □ NOT PREGNANT □ 1st TRIMESTER □ 2nd TRIMESTER □ 3rd TRIMESTER

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 : _____ **DATE :** _____

OFFICE REVIEWED _____