pacific northwest EYE associates

Patient Medical History

Patient ID# _____ Name _____ Date _____

Date of Birth _____ Age _____ ☐ Male ☐ Female Height _____ Weight _____

Primary Language _____ Specialty Physician _____

Primary Care Physician _____ Date of Last Visit _____

Please list all allergies (medication, herbals, food, environmental) ☐ **No known allergies** ☐ Latex ☐ Betadine

_____

_____

Please list all previous surgeries and recent hospitalizations

_____

_____

Please list all medications you are currently taking. (prescription, over-the-counter, herbal)

MEDICATION NAME	DOSAGE	AMOUNT TAKEN/HOW OFTEN	REASON FOR MEDICATION

Please check (✓) response

Have you ever smoked or still smoke? If yes, for how long? _____ Packs per day? _____ Year quit? _____	☐ Yes ☐ No	Have you taken oral steroids within the last 6 months? If so, which? _____	☐ Yes ☐ No
Do you drink alcohol? If yes, how much/often? _____	☐ Yes ☐ No	Have you been diagnosed with MRSA? If yes, when and where were you treated? _____	☐ Yes ☐ No
Do you use recreational drugs? If Yes, which and how often? _____	☐ Yes ☐ No	Do you have caps, bridges, dentures, or loose teeth?	☐ Yes ☐ No
Do you take blood thinners such as aspirin, ibuprofen, Coumadin, Plavix? If yes, which? _____	☐ Yes ☐ No	Have you or your immediate family had unusual reactions, problems, or complications associated with anesthesia? If yes, describe: _____ _____ _____	☐ Yes ☐ No
Have you used diet pills in the last 2 weeks? If yes, which? _____	☐ Yes ☐ No		
Do you exercise? Type/frequency? _____	☐ Yes ☐ No		

Please check (✓) response.

Neurological	
Headaches/Seizures	☐ Yes ☐ No
Stroke/Aneurysm	☐ Yes ☐ No
Fainting	☐ Yes ☐ No
Paralysis/Neuropathy	☐ Yes ☐ No
Numbness/Tingling/Weakness	☐ Yes ☐ No
Restless Leg Syndrome	☐ Yes ☐ No
Anxiety/Depression	☐ Yes ☐ No
Memory Loss	☐ Yes ☐ No
Other:	

Heart/Cardiovascular	
High Blood Pressure	☐ Yes ☐ No
High Cholesterol/Lipids	☐ Yes ☐ No
Chest Pain/Abnormal Sensation with Exertion	☐ Yes ☐ No
Difficulty Breathing While Lying Flat	☐ Yes ☐ No
Irregular Heartbeat	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No
Angioplasty/Stent	☐ Yes ☐ No
Bypass Surgery Date: _____	☐ Yes ☐ No
Heart Valve Problems/Surgery	☐ Yes ☐ No
Heart Failure/Swelling of Your Feet	☐ Yes ☐ No
Rheumatic Fever/Endocarditis	☐ Yes ☐ No
Pacemaker/Defibrillator	☐ Yes ☐ No
Peripheral Vascular Disease/Surgery	☐ Yes ☐ No
Other:	

LUNGS	
Shortness of Breath/Wheezing	☐ Yes ☐ No
Asthma/COPD	☐ Yes ☐ No
Chronic Cough	☐ Yes ☐ No
Snoring/Sleep Apnea/CPAP Machine	☐ Yes ☐ No
Pneumonia/Aspiration	☐ Yes ☐ No
Pulmonary Hypertension	☐ Yes ☐ No
Blood clot in Lungs/Legs Date: _____	☐ Yes ☐ No
Other:	

Gastrointestinal	
Heart Burn/Acid Reflux	☐ Yes ☐ No
Peptic Ulcers/GI Bleed	☐ Yes ☐ No
Jaundice/ Liver Disease/Hepatitis/Cirrhosis	☐ Yes ☐ No
Pancreatitis	☐ Yes ☐ No
Motion Sickness/Irritable Bowel Syndrome	☐ Yes ☐ No
Other:	

Endocrine	
Diabetes (if yes, how controlled) ☐ Diet ☐ Oral Med ☐ Insulin	☐ Yes ☐ No
Hyperthyroidism/Hypothyroidism	☐ Yes ☐ No
Other Endocrine Diseases Type: _____	☐ Yes ☐ No

Blood Disorders (Hematology)	
HIV/AIDS	☐ Yes ☐ No
Anemia/Bleeding Disorders	☐ Yes ☐ No
Other:	

Cancer/Malignancy	
Cancer - Type: _____	☐ Yes ☐ No
Chemotherapy - Date: _____	☐ Yes ☐ No
Radiation - Date: _____	☐ Yes ☐ No
Other:	

Musculoskeletal	
Arthritis	☐ Yes ☐ No
TMJ/Jaw Pain	☐ Yes ☐ No
Back/Neck Pain	☐ Yes ☐ No
Artificial Joint Replacement or Metal Implanted Devices Location: _____	☐ Yes ☐ No
Other:	

Urological/Kidney Disease	
Kidney Disease/Renal Failure	☐ Yes ☐ No
Dialysis/Kidney Transplant	☐ Yes ☐ No
Prostate Disease	☐ Yes ☐ No
Do you take medication for urination problems? Name of Medication: _____	
Other:	

(Female Patients Only) Last Menstrual Period: _____

Do you require assistance walking? Check one:
☐ None ☐ Cane ☐ Walker ☐ Wheelchair

Has Medical Power of Attorney for your care been assigned to another individual? If so, whom? (***Must provide copy of POA)*** _____	☐ Yes ☐ No

I hereby attest that this information is true, accurate, and complete to the best of my knowledge.

Name: _____

Signature: _____

Date: _____