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 and 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		Gastrointestinal	
Stroke/TIA	☐ Yes ☐ No	Heartburn	☐ Yes ☐ No
Paralysis	☐ Yes ☐ No	Acid reflux	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	Peptic ulcers/GI bleed	☐ Yes ☐ No
Memory loss	☐ Yes ☐ No	Hepatitis/Liver disease/Jaundice	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Motion sickness	☐ Yes ☐ No
Head injury	☐ Yes ☐ No	**Endocrine**	
Fainting	☐ Yes ☐ No	Diabetes (if yes, indicate how controlled) ☐ Diet ☐ Oral Med ☐ Insulin	☐ Yes ☐ No
Depression/anxiety	☐ Yes ☐ No		
Restless Leg Syndrome	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No
Heart/Cardiovascular		Hyperthyroidism	☐ Yes ☐ No
Heart Attack Date _____	☐ Yes ☐ No	Hypothyroidism	☐ Yes ☐ No
Angina/chest pain Date _____	☐ Yes ☐ No	**Blood Disorders (Hematology)**	
High blood pressure	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No
Congestive heart failure	☐ Yes ☐ No	Blood Transfusion? Date _____	☐ Yes ☐ No
Irregular heart beat	☐ Yes ☐ No	**Cancer/Malignancy**	
Heart murmur/valve	☐ Yes ☐ No	Cancer? Type? _____	☐ Yes ☐ No
Rheumatic heart fever	☐ Yes ☐ No	Chemotherapy? Date _____	☐ Yes ☐ No
Swelling of the feet	☐ Yes ☐ No	Radiation? Date _____	☐ Yes ☐ No
Abnormal sensations w/ exertion? If yes, location (check one) ☐ Chest ☐ Arms ☐ Neck Date of last event _____	☐ Yes ☐ No	**Musculoskeletal**	
		Arthritis	☐ Yes ☐ No
		Back/neck pain	☐ Yes ☐ No
High cholesterol/lipids	☐ Yes ☐ No	TMJ/jaw pain	☐ Yes ☐ No
Implanted defibrillator	☐ Yes ☐ No	Artificial joint replacement or metal implanted devices? Location _____	☐ Yes ☐ No
Can you walk two (2) flights of stairs without stopping?	☐ Yes ☐ No		
Pacemaker? Last battery check _____	☐ Yes ☐ No	**Urological/Kidney**	
		Kidney disease	☐ Yes ☐ No
Angioplasty/stent? Date _____	☐ Yes ☐ No	Dialysis	☐ Yes ☐ No
		Prostate disease	☐ Yes ☐ No
Lungs (Pulmonary)		Do you take medication for urination problems? If yes, please state which medication you take? _____	☐ Yes ☐ No
Emphysema/COPD	☐ Yes ☐ No		
Snoring/Sleep Apnea	☐ Yes ☐ No		
Do you use a CPAP device?	☐ Yes ☐ No	**(Female patients only)** Last menstrual period _____	
Chronic cough	☐ Yes ☐ No	**Do you require assistance walking? Check one:** ☐ **None** ☐ **Cane** ☐ **Walker** ☐ **Wheelchair**	
Recent cold or flu? Date _____	☐ Yes ☐ No		
Pneumonia? Date _____	☐ Yes ☐ No	Has Medical Power of Attorney for your care been assigned to another individual? If so, whom? _____ ***Must provide copy of POA***	☐ Yes ☐ No
Blood clot in lungs/legs	☐ Yes ☐ No		

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

Patient Signature _____ **Date** _____