PATIENT HISTORY AND REVIEW OF SYSTEMS *PLEASE PRINT*

TWO SIDED FORM REQUIRED BY YOUR INSURANCE PROVIDER

NAME _____ **BIRTHDATE** _____ **TODAY'S DATE** _____

Preferred Language: ○ English ○ Other_____ Gender: ○ Male ○ Female

Race: _____ Ethnicity: _____

_____ _____

Medications Including Current Ocular Medications

○ I am not on any prescription medications.

○ I am on blood thinner medication or aspirin.

1) _____

2) _____

3) _____

4) _____

Eye drops? _____

Allergies

○ No known allergies

_____

_____

_____

_____

_____

Past Ocular History

No	Yes		Eye	Date	No	Yes		Eye	Date
○	○	Cataract	_____	_____	○	○	Glaucoma	_____	_____
○	○	Strabismus(lazy eye)	_____	_____	○	○	Macular Degeneration	_____	_____
○	○	Retinal Detachment	_____	_____	○	○	Refractive Surgery	_____	_____
○	○	Other	_____	_____					

Medical/Surgical History

No	Yes	Cardiovascular	No	Yes	Immunologic
○	○	High Blood pressure_____	○	○	Rheumatoid Arthritis_____
○	○	Heart Attack _____	○	○	Multiple Sclerosis_____
○	○	Heart Stent_____	○	○	Kidney Failure _____
○	○	Stroke_____	○	○	Cancer_____Type_____
		Endocrine	○	○	Other _____
○	○	Diabetes _____			_____
○	○	Thyroid _____			

○ List any surgeries you have had_____

_____

Family History

No	Yes		Relation	No	Yes		Relation	No	Yes		Relation
○	○	Amblyopia	_____	○	○	Macular Degeneration	_____	○	○	Blindness	_____
○	○	Glaucoma	_____	○	○	Cataracts	_____	○	○	Heart Disease	_____
○	○	Arthritis	_____	○	○	Diabetes	_____	○	○	Cancer	_____

CONTINUE ON REVERSE SIDE

Social History

Current Smoking Status:

Have you ever used tobacco?	**No**	**Yes**
Every day	○	○
Occasionally	○	○
Previously	○	○

	No	**Yes**	Previous	Amount	How Often?
Alcohol?	○	○	○	_____	_____

For Patients 65 and Older:

	No	**Yes**	**#Falls**
Falls in the last year:	○	○	_____
Did fall result in injury?	○	○	Date: _____

Details: _____

_____

_____

Vaccinations:

	No	**Yes**	
Influenza	○	○	Date:_____
Pneumonia	○	○	

REVIEW OF SYSTEMS: Do you currently have any of the following:

Constitutional

No	**Yes**	
○	○	fatigue
○	○	fever
○	○	weight loss

Ears/Nose/Mouth/Throat

No	**Yes**	
○	○	bulging eyes
○	○	hearing loss
○	○	sinus problems
○	○	vertigo

Respiratory

No	**Yes**	
○	○	asthma
○	○	cough
○	○	shortness of breath

Cardiovascular

No	**Yes**	
○	○	Chest pressure or discomfort
○	○	irregular heartbeat/ palpitations

Gastrointestinal

No	**Yes**	
○	○	abdominal pain
○	○	black tarry stools
○	○	jaundice
○	○	nausea

Genitourinary

No	**Yes**	
○	○	painful urination
○	○	genital lesions
○	○	urethral discharge
○	○	kidney failure

Metabolic/Endocrine

No	**Yes**	
○	○	cold intolerance
○	○	heat intolerance
○	○	always thirsty

Neurological

No	**Yes**	
○	○	weakness
○	○	headache
○	○	memory difficulty
○	○	numbness of extremities

Psychiatric

No	**Yes**	
○	○	depressed mood
○	○	hallucinations
○	○	irritability
○	○	nervousness

Integumentary

No	**Yes**	
○	○	rash
○	○	skin sores

Musculoskeletal

No	**Yes**	
○	○	back pain
○	○	fracture
○	○	joint swelling
○	○	muscle weakness

Hematologic/Lymphatic

No	**Yes**	
○	○	bleeding
○	○	bruising
○	○	**l**ymphadenopathy (swollen lymph nodes)
○	○	tender lymph nodes

Immunologic

No	**Yes**	
○	○	environmental allergies
○	○	seasonal allergies

PLEASE COMPLETE and SIGN:

The Spokane Eye Clinic staff and Doctors may need to contact you regarding test results or other health-related information. Our preference is to talk with you directly, If we cannot reach you, may we leave test results or other patient health information on your voice mail? ○ Yes ○ No

Which number should we call? ○ Cell ○ Home ○ Work

If we reach a family member, may we leave test results with them? ○ Yes ○No

Family Member Name: _____

Name of Patient/Legal Guardian (please print) _____

Signature: _____