EMPIRE EYE
PHYSICIANS
EmpireEye.com

COEUR D'ALENE OFFICE
2175 N. Main St. (Riverstone), Coeur d'Alene, ID 83814
Phone (208) 664-9888 | Fax (208) 666-0816

SPOKANE VALLEY OFFICE
1414 N. Houk Rd., Suite 103, Spokane Valley, WA 99216
Phone (509) 928-8040 | Fax (509) 928-0784

Patient Medical History Form

Name_____ **Date**_____ **Birth Date**_____

Ocular History

☐ Cataracts ☐ Glaucoma ☐ Lazy Eye ☐ Corneal Conditions ☐ Retinal Injury
☐ Eye Injury ☐ Eye Surgery ☐ Eye Infections ☐ Dry-Eye ☐ Macular Degeneration
☐ Prominent Eyes ☐ Crossed Eyes ☐ Sjogren's ☐ Other _____

Do you wear corrective lenses?

☐ Glasses How old is your current prescription? _____
☐ Contacts What type? ☐ Soft ☐ Rigid ☐ Scleral Are they comfortable? ☐ Yes ☐ No

Ocular Surgeries

☐ RK/ PRK ☐ Cataract ☐ Retina ☐ LASIK ☐ Lids ☐ Other: _____

Patient Family History (please mark if you have a known family history of an ocular condition)

☐ Cataracts ☐ Glaucoma ☐ Corneal Conditions ☐ Retinal Disease ☐ Other _____

Medical History

☐ Allergies/ Hay Fever ☐ Anemia ☐ Asthma ☐ Arthritis (☐ Rheumatoid)
☐ Bladder Issues ☐ Bleeding Issues ☐ Cancer (Type)_____
☐ Cardiac Conditions ☐ Chest Pain/ Angina ☐ Chronic Bronchitis ☐ Chronic Cough
☐ Constipation ☐ COPD ☐ Diabetes ☐ Diarrhea
☐ Dry Throat/ Mouth ☐ Emphysema ☐ Heart Attack/ MI ☐ High Cholesterol
☐ Hypertension ☐ Hyperthyroidism ☐ Hypothyroidism ☐ Liver Failure
☐ Psychiatric ☐ Renal Disease/ Failure ☐ Stroke Rapid Weight ☐ Gain ☐ Loss
☐ Seizures ☐ Sinus Issue ☐ Other _____

Hospitalization/ Surgeries _____

Allergies _____ **Type of Reaction** _____

Do you use tobacco products? ☐ Yes ☐ No
Type/ How long? _____

Do you drink alcohol? ☐ Yes ☐ No
Frequency? _____

Do you use illicit drugs? ☐ Yes ☐ No

Do you drive? ☐ Yes ☐ No

Are you pregnant or nursing? ☐ Yes ☐ No

Do you take photosensitive medications? ☐ Yes ☐ No

Were you exposed to or are infected with the following? ☐ HIV ☐ Syphilis ☐ Herpes ☐ Gonorrhea

Medications If more than 3 medications, please provide a separate list.

Medication	Dose	Frequency

DIABETIC INFORMATION
Last A1C _____ Date _____
Fasting Glucose_____ Date _____
Specialist _____