EMPIRE EYE
PHYSICIANS
EmpireEye.com

COEUR D'ALENE OFFICE
2175 N. Main St. (Riverstone), Coeur d'Alene, ID 83814
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SPOKANE VALLEY OFFICE
16010 E. Indiana Ave., Spokane Valley, WA 99216
Phone (509) 928-8040 | Fax (509) 928-0784

Patient Medical History Form

Name: _____ **Date:** _____ **MRN:** _____

Sex: ◯ **Male** ◯ **Female** **Date of Birth:** _____ **SSN:** _____

Who is your medical doctor? _____ **Did a doctor refer you?** _____ **If so, who?** _____

Past Medical History

Yes	No	
◯	◯	Cancer: Type, location _____
◯	◯	Diabetes Type: _____ A1C: _____
◯	◯	Heart Disease (Explain: _____)
◯	◯	High Blood Pressure (BP)
◯	◯	Lung Disease (Asthma, Emphysema, COPD, Chronic bronchitis)
◯	◯	Eye Surgery; Date/Reason: _____
◯	◯	Other Surgery; Date/Reason: _____
◯	◯	Other Illness/Injury: _____

Do you currently have any of these problems?

Yes	No	
◯	◯	Heart Disease (Heart attack, Angina, AFIB, Arrhythmia, Heart failure, Heart valve disease, Bypass surgery)
◯	◯	Heartburn, Abdominal pain, Diarrhea, Vomiting, Weakness, or Numbness
◯	◯	Thyroid Disease (Hypo, Hyper, Graves' Disease)
◯	◯	Gastrointestinal Disease (Ulcers, Esophageal reflux, Intestinal)
◯	◯	Genitourinary Disease (Kidney disease, Dialysis, Kidney stones)
◯	◯	Blood Problems (Anemia, Leukemia, Clotting problems)
◯	◯	Ear, Nose, Throat (Hearing loss, Sinus disease)
◯	◯	Skin Problem (Eczema, Psoriasis, Acne rosacea)
◯	◯	Joint Pain, Arthritis (Rheumatoid, Osteodegenerative)
◯	◯	Neurological Problems (Stroke, Seizure, Paralysis)
◯	◯	Psychiatric (Depression, Anxiety, Schizophrenia, Bipolar)
◯	◯	Respiratory (Shortness of breath, Wheezing, Coughing)
◯	◯	Infectious Disease (TB, Hepatitis, Syphilis, Gonorrhea, HIV/AIDs)

Ophthalmic History

	Yes	No
Lazy Eye	◯	◯
Cataract	◯	◯
Corneal Disease	◯	◯
Diabetic Eye Problem	◯	◯
Glaucoma	◯	◯
Iritis	◯	◯
Macular Degen.	◯	◯
Crossed Eyes	◯	◯
Retinal Detach.	◯	◯

Family History

	Yes	No
Blindness	◯	◯
Cancer	◯	◯
Diabetes	◯	◯
Glaucoma	◯	◯
Retinal Disease	◯	◯
Heart Disease	◯	◯
High BP	◯	◯

Other: _____

Social History (Circle)

Marital Status: M S D W

Do you live alone? Y N

Tobacco: Y N

Alcohol: Y N

Allergies / Reaction

_____

Please list all of your current medications on the back of this sheet.

⇨⇨ **FLIP PAGE OVER** ⇨⇨

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Systemic Medications

Eye Medications