

FORM B

PATIENT MEDICAL HISTORY RECORD

PATIENT NAME: _____ DATE: _____

MEDICAL STATUS AND HISTORY

1. HAVE YOU EVER BEEN TREATED FOR ANY MEDICAL CONDITIONS (E.G., DIABETES, HIGH BLOOD PRESSURE, ARTHRITIS, ETC.)?
YES NO YES, PLEASE EXPLAIN:

2. HAVE YOU EVER BEEN DIAGNOSED WITH SLEEP APNEA OR DO YOU USE A C-PAP MACHINE?
YES NO YES, PLEASE EXPLAIN:

3. HAVE YOU HAD PREVIOUS SURGERIES YES NO YES, PLEASE LIST

4. DO YOU TAKE ANY MEDICATIONS? YES NO YES, PLEASE LIST

5. DO YOU TAKE ANY EYE MEDICATIONS? YES NO YES, PLEASE LIST

6. DO YOU HAVE ANY DRUG ALLERGIES YES NO YES, PLEASE LIST

7. HAVE YOU HAD ANY EYE INJURIES OR OPERATIONS? YES NO YES, PLEASE LIST

REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS?

CHRONIC FEVER, UNEXPECTED WEIGHT LOSS/GAIN, FATIGUE Y N

EXPLAIN _____

EAR/NOSE/THROAT PROBLEMS (E.G., HEARING LOSS, SINUS PROBLEMS, SORE THROAT) Y N

EXPLAIN _____

HEART PROBLEMS (E.G., CHEST PAIN, IRREGULAR HEART BEAT) Y N

EXPLAIN _____

RESPIRATORY PROBLEMS (EG., SHORTNESS OF BREATH, WHEEZING, COUGHING) Y N

EXPLAIN _____

REVIEW OF SYSTEMS (CONTINUED)

GASTROINTESTINAL PROBLEMS (EG., HEARTBURN, ABDOMINAL PAIN, DIARRHEA) Y N
EXPLAIN _____

URINAL PROBLEMS (E.G., PAIN OR DISCOMFORT, BLOOD IN URINE) Y N
EXPLAIN _____

SKIN PROBLEMS (EG., RASHES, EXCESSIVE DRYNESS) Y N
EXPLAIN _____

MUSCULOSKELETAL PROBLEMS (E.G., MUSCLE ACHES, JOINT PAIN, SWOLLEN JOINTS) Y N
EXPLAIN _____

NEUROLOGIC PROBLEMS (EG., NUMBNESS, WEAKNESS, HEADACHES, PARALYSIS) Y N
EXPLAIN _____

PSYCHIATRIC PROBLEMS (E.G., DEPRESSION, ANXIETY) Y N
EXPLAIN _____

DO YOU SMOKE? Y N HOW MUCH? _____ DO YOU DRINK? Y N HOW MUCH? _____

FAMILY HISTORY

DO ANY MEDICAL OR EYE DISEASES RUN IN YOUR FAMILY (E.G.) DIABETES, HIGH BLOOD PRESSURE, CANCER, GLAUCOMA, MACULAR DEGENERATION)?

REASON FOR TODAYS EXAM

Northwest Eye & Laser Center is committed to protecting the privacy of your personal information. We are required by applicable federal and state laws to maintain the privacy of your personal and health information. This notice explains our privacy practices, our legal duties, and your rights concerning your personal and health information. Personal and health information means any information that is identifiable to you as your personal information, including information regarding your health care and treatment; identifiable factors including your name, age, address, income or other financial information.

I acknowledge that I have been informed by Northwest Eye & Laser Center that upon my request, I will be furnished with a Notice of Privacy Practices.

Signed (Patient or parent if minor) _____ Date _____

Relationship (Patient or parent if minor) _____

