# ***Health History***

## *IC Laser Eye Care*

Last Name_____First Name_____M_____

Address _____Apt:_____

City or Town_____State_____Zip_____

Date of Birth_____/_____/_____Age_____Social Security #_____-_____-_____

Phone Numbers Home (____)_____-_____ Cell (____)_____-_____

Email_____

Emergency Contact_____(____)_____-_____

Primary Care Physician_____(____)_____-_____

Last Date your were seen by your Primary Care Physician? _____/_____/_____

Current Pharmacy_____(____)_____-_____

If minor, name of person responsible for account_____

Relationship to patient_____(____)_____-_____

Sex: M____ F_____

Occupation_____

Do You Drink Alcohol? Rarely_____ Moderately_____

Daily_____

Do You Smoke Tobacco? Never_____ Yes, pack/day_____ Quit/Date_____

Past or present drug use? Y____ N____ (important for drug and anesthetic interactions)

Have you ever had a blood transfusion since 1977? Y____ N_____.

Is there anything else you feel the doctor needs to know_____

# ***Health History***

Have you had any of the following medical problems? ***Please circle Yes or No***

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Yes | No | Weight Loss | Yes | No | Lack of Energy | Yes | No | Trouble Sleeping |
| Yes | No | Heart Attack | Yes | No | Stroke | Yes | No | Heart Murmur |
| Yes | No | Mitral Valve Prolapse | Yes | No | High Blood Pressure | Yes | No | Seizures |
| Yes | No | Circulation Problems | Yes | No | High Cholesterol | Yes | No | Asthma |
| Yes | No | Chest Pain | Yes | No | Arthritis | Yes | No | Muscle Pain |
| Yes | No | Paralysis/weakness | Yes | No | Numbness | Yes | No | Mania/Bipolar |
| Yes | No | Emphysema | Yes | No | Bruising easily | Yes | No | Ulcers(stomach) |
| Yes | No | Anemia(low blood count) | Yes | No | Hepatitis | Yes | No | Lupus |
| Yes | No | Tuberculosis (TB) | Yes | No | Constipation | Yes | No | Muscle pain |
| Yes | No | Rashes, Sensitivities | Yes | No | Skin Cancer | Yes | No | Urinary Infection |
| Yes | No | Chemical imbalance | Yes | No | Migraines | Yes | No | Kidney Infection |
| Yes | No | Schizophrenia | Yes | No | Excessive Bleeding | Yes | No | HIV |
| Yes | No | Clotting Problems | Yes | No | Thyroid Condition | Yes | No | Breast Cancer |
| Yes | No | Shortness of breath | Yes | No | Osteoporosis | Yes | No | Diverticulitis |
| Yes | No | Cancer _____ | Yes | No | Diabetes If Yes, when were you diagnosed?_____ | | | |

Are you insulin dependent?_____Last Blood Sugar?_____Last Hemoglobin A1c?_____Date_____

Please list all current Medications including over the counter supplements:_____

_____

_____

_____

_____

_____

_____

Please list any prior surgeries: _____

_____

_____

_____

## ***Allergies*** ***Please circle all that apply***

None Penicillin Sulfa Fluorescein Iodine Dyes ShellFish Latex

Other_____

## ***Family History***

**Have any of your immediate family members have any of the following? Please Circle?**

| | | | | |
|---|---|---|---|---|
| Diabetes | Thyroid condition | Stroke | Anemia | Hepatitas |
| High Blood Pressure | Kidney Disease | | Bleeding Disease | HIV |
| Tuberculosis | Heart Disease | | | |

# ***Health History***