PATIENT HISTORY AND REVIEW OF SYSTEMS *PLEASE PRINT*

TWO-SIDED FORM REQUIRED BY YOUR SPOKANE EYE CLINIC PROVIDER

NAME: _____ BIRTHDATE: _____ TODAY'S DATE: _____

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

SS#:_____Phone#: (___)_____ Patient Address: _____

Address Continued:_____ Email Address:_____

Patient Employer: _____ Employer Phone: _____

Pharmacy Name: _____ Pharmacy Phone #: _____

Primary Care Physician: _____ Referring Physician:_____

INSURANCE INFORMATION:

Primary Insurance: _____ Policyholder's Name: _____

Policyholder's ID # _____ DOB:_____ Group #:_____

Secondary Insurance: _____ DOB:_____ Policyholder's Name: _____

Policyholder's ID # _____ DOB:_____ Group #:_____

Work Related: Yes / No Date of Injury: _____ L&I Carrier:_____

Past Ocular History

No	Yes		Eye	Date
O	O	Cataract	_____	_____
O	O	Strabismus (lazy eye)	_____	_____
O	O	Retinal Detachment	_____	_____
O	O	Other	_____	_____

No	Yes		Eye	Date
O	O	Glaucoma	_____	_____
O	O	Macular Degeneration	_____	_____
O	O	Refractive Surgery	_____	_____
O	O	Other	_____	_____

Medical/Surgical History

No Yes Cardiovascular

O O High Blood pressure_____

O O Heart Attack _____

O O Heart Stent_____

O O Stroke_____

Endocrine

O O Diabetes _____

O O Thyroid _____

O O Other _____

No Yes Immunologic

O O Rheumatoid Arthritis _____

O O Multiple Sclerosis _____

O O Kidney Failure _____

Pulmonary

O O Asthma _____

O O COPD _____

O O Oxygen Dependent _____

O O Cancer_____ Type_____

O List any surgeries you have had _____

_____

CONTINUE ON REVERSE SIDE ⟶

Family History

No	Yes		Relation
○	○	Amblyopia	_____
○	○	Glaucoma	_____
○	○	Arthritis	_____

No	Yes		Relation
○	○	Macular Degeneration	_____
○	○	Cataracts	_____
○	○	Diabetes	_____

No	Yes		Relation
○	○	Blindness	_____
○	○	Heart Disease	_____
○	○	Cancer	_____

Emergency Contact: _____ Emergency Phone: _____

Social History

Current Smoking Status:

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

For Patients 65 and Older:

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

Details: _____

_____

_____

_____

***I give my consent to access my medication history electronically. Please initial: _____Yes_____No**

Medications Including Current Ocular Medications

○ I am not on any prescription medications.

○ I am on blood thinner medication or aspirin.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____
11) _____
12) _____
13) _____
14) _____
15) _____

Allergies

○ No known allergies / Latex Allergy Y / N

_____

_____

_____

_____

_____

_____

_____

_____

Eye Drops:

_____

_____

_____

_____

_____

_____