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:_________________________

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Please list any prior surgeries: ____

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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			

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