WASHINGTON PACIFIC EYE ASSOCIATES MEDICAL HISTORY FORM

Patient Legal Name: ________________________________ **Date of Birth** ___/___/___
Patient Preferred Name:______________________________________
Sex Assigned at Birth: ☐**M** ☐**F** **Gender Identity:**__________________ **Pronouns:**_____________

MEDICAL HISTORY: (Do you have the following?)

DIABETES: ……………………….. **yes** ☐ no ☐
If yes, for how many years? ____________ Highest blood sugar within the past month? _______
Any breathing problem: …………..... **yes** ☐ no ☐
High blood pressure: ……………….... **yes** ☐ no ☐
HIV: ……………………………….... **yes** ☐ no ☐
History of cancer: ………………….. **yes** ☐ no ☐ type/date____
Previous stroke: …………………….. **yes** ☐ no ☐
Do you have any other medical problem(s)? (☐ **NONE)** ____

EYE HISTORY:

Do you have any **eye disease?**……… **yes** ☐ no ☐
If yes, please provide
details:____
When was your **last eye exam**? _________
Do you use **contact lenses:** ……….... **yes** ☐ no ☐ Do you use Soft ☐ or Rigid Gas Permeable lenses (hard lenses) ☐
Do you wear **glasses**? ………………. **yes** ☐ no ☐ → ☐ check here if glasses are **only** for reading
Ever been **hit in your eye**?.. **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐
Have you had eye **surgery** before?..... **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐
If yes, please provide details and dates: ______________________________________
Have you had **laser** eye surgery?........ **yes** ☐ no ☐ → Which eye? Right ☐ Left ☐ Both ☐
If yes, please provide details and dates: ______________________________________

SOCIAL HISTORY

Do you smoke? ……………. **yes** ☐ no ☐
Current Occupation ______________________
Do you drink alcohol? ………. **yes** ☐ no ☐
Do you drive? ……………. **yes** ☐ no ☐

ALLERGIES:

Are you **allergic** to any medicine:…………… **yes** ☐ no ☐
If yes, please provide name(s) of the medicine(s):….-
____

MEDICATIONS:

-
____
____
____

FAMILY HISTORY:

Anyone in your family have **glaucoma**?.......... **yes** ☐ no ☐
If yes, who: ______________________
Any **eye disease** that runs in your family?........**yes** ☐ no ☐
If yes, please explain:_________________________
Is anyone in your family **cross-eyed**?.....**yes** ☐ no ☐
Anyone in your family **blind**?................**yes** ☐ no ☐

GENERAL MEDICAL QUESTIONS: (Do you have the following?)

Fever:…………………………………………**yes** ☐ no ☐
Frequent Headaches: ………………………… **yes** ☐ no ☐
Are you pregnant: ……………………………**yes** ☐ no ☐
Muscle weakness: ……………………………**yes** ☐ no ☐
Numbness: ……………………………………**yes** ☐ no ☐
Rash: …………………………………………**yes** ☐ no ☐
Cough: ……………………………...........**yes** ☐ no ☐
Have you had a heart attack: ………………… **yes** ☐ no ☐
History of Tuberculosis: ……………………...**yes** ☐ no ☐
If yes, when were you treated? ________
Diarrhea: ……………………………… **yes** ☐ no ☐
Blood in your stool: ……..…………… **yes** ☐ no ☐
Recent weight loss: …………………… **yes** ☐ no ☐
Recent decreased appetite: ……….……**yes** ☐ no ☐
Pain when you urinate: ……………..… **yes** ☐ no ☐
Joint pain: …………………………….. **yes** ☐ no ☐
Muscle pain: ………………………….. **yes** ☐ no ☐
Low back pain: ……………………….. **yes** ☐ no ☐

PATIENT INFORMATION

Patient Legal Name:____ Age:____
LAST FIRST MI

Patient Preferred Name:____

Patient Address:________________________________ Unit/Apt #: _________

City: _____________ State:_____ Zip:_________

Primary #: (_____) ______ - _______ Secondary #: (_____) ______ - _______

Email address_____________________________

Date of Birth: _____ / ____ / ____ Social Security Number: _____ - ___ - _____

Sex Assigned at Birth: ☐M ☐F Gender Identity:_________________ Pronouns: ________________

Emergency Contact Name: ____________________Emergency Contact Phone: __________________

Name of Responsible Party: (☐self)__________________________ Relationship to patient:_________

Primary Doctor: _________________________

HIPAA STATEMENT

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I have read and agree with Washington Pacific Eye Associates' ***HIPAA Notice of Privacy Policy*** and I may request a copy for my records

I hereby authorize Washington Pacific Eye Associates to furnish to my insurance company or authorizing agency information regarding my protected health information for the purposes of treatment, payments, or health care operations. I further authorize the physician(s) of Washington Pacific Eye Associates to consult as needed in their sole discretion with other medical providers regarding my medical care.

____ _______________
Signature of Responsible Party Date

____
Print Patient Name