212 Rodeo Drive, Suite 410 Moscow, ID 83843 ❖ 208-874-0020 ❖ www.inlandeyecare.com ❖ admin@inlandeyecare.com

PATIENT HISTORY

Patient Name:		**Preferred phone:**	
Guardian Name: (if applicable)		**Other phone:**	
Date of birth:		**SSN:**	
Gender:		**Email:**	
Address:		**City, State, and Zip:**	
Marital Status:		**Race/Ethnicity:**	
Preferred language:		**Preferred pharmacy:**	
Primary Care Physician:		**Date of last visit:**	

MEDICAL HISTORY

Height___________ Weight___________

Do you have any allergies to medications? ☐ Yes ☐ No If yes, please list______________________________

Do you have any environmental allergies? ☐ Yes ☐ No If yes, please list______________________________

List all medication you take (including oral contraceptives, aspirin, over the counter medications and home remedies).

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____

List MAJOR injuries, surgeries, and/or hospitalizations you have had.

____

Do you now or have you ever experienced any problems in the following areas? Please circle all that apply.

Constitutional	Cardiovascular	Ear/Nose/ Throat	Respiratory	Gastrointestinal	Genitourinary	Musculoskeletal
Fever Weight loss Weight gain Dizziness Vertigo Cancer	High blood pressure Stroke Heart Disease Atrial fibrillation	Hearing loss Sinus congestion Chronic cough Dry throat Dry mouth	Sleep apnea Asthma Chronic bronchitis Emphysema COPD	Crohn's IBS Acid reflux Digestive difficulties	Genital problem Kidney disorder Bladder disorder Prostate disease	Arthritis Gout Fibromyalgia Osteoporosis Muscle/joint pain
Integumentary/ skin	**Neurological**	**Endocrine**	**Psychiatric**	**Hematologic/ Lymphatic**	**Allergic/ Immunologic**	**Other**
Eczema Psoriasis Shingles Cold sores Rosacea	Headaches Migraines Multiple Sclerosis Seizures/Epilepsy Tumor	Type 1 Diabetes Type 2 Diabetes Thyroid dysfunction	Depression Anxiety Panic Disorder Bipolar	Bleeding Problems Anemia High cholesterol	Rheumatoid Arthritis Lupus Sjogren's Seasonal allergies	

FAMILY HISTORY

Eye diseases:	☐ Glaucoma ☐Macular degeneration ☐ Cataracts ☐ Retinal disease ☐ Corneal disease ☐ Crossed eyes
Systemic diseases:	☐ Diabetes ☐ High blood pressure ☐ Cancer ☐ Heart disease ☐ Thyroid disease ☐ Heart attack ☐ Stroke
Other:	

OCULAR HISTORY								
When and where was your last eye examination?								
Indicate the visual correction that you wear. Please circle all that apply.								
Glasses	Constant wear		Distance only	Reading only				
Contacts	Soft	Gas permeable	Are they comfortable?	☐ Yes	☐ No			
How often do you replace your contacts? ☐ Daily ☐ 1-2 Weeks ☐ Monthly ☐ Other ______								
What brand of contacts do you wear?			How many hours per day do you usually wear them?					
Which of the following have you had? ☐ Crossed eyes ☐ Lazy eye ☐ Drooping eyelid ☐ Eye infection ☐ Eye injury ☐ Eye surgery ☐ Glaucoma ☐ Cataracts ☐ Macular degeneration ☐ Retinal disease ☐ Other ______								
Current eye symptoms – Do you experience any of the following **with** current spectacle/contact lens correction?								
Blurred vision	☐ Yes	☐ No	Eye pain	☐ Yes	☐ No	Color vision difficulties	☐ Yes	☐ No
Distorted vision	☐ Yes	☐ No	Gritty/sandy eyes	☐ Yes	☐ No	Depth perception problems	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Discharge from eyes	☐ Yes	☐ No	Losing place while reading	☐ Yes	☐ No
Red eyes	☐ Yes	☐ No	Tired eyes	☐ Yes	☐ No	Night vision problems	☐ Yes	☐ No
Watery eyes	☐ Yes	☐ No	Dry eyes	☐ Yes	☐ No	Light/glare sensitivity	☐ Yes	☐ No
Itchy eyes	☐ Yes	☐ No	Floating spots	☐ Yes	☐ No	Sties/chalazion	☐ Yes	☐ No
Burning eyes	☐ Yes	☐ No	Excessive squinting	☐ Yes	☐ No	Other		
Flashing lights	☐ Yes	☐ No	Seeing rings around lights	☐ Yes	☐ No			

SOCIAL HISTORY This information is kept strictly confidential.					
Occupation:			Employer:		
Do you drive?	☐ Yes	☐ No	If yes, do you have difficulty when driving?	☐ Yes	☐ No
If yes, please describe**:**					
Do you use tobacco/nicotine products?	☐ Yes	☐ No	If yes, type/amount/how long?		
If former tobacco/nicotine user, how long ago did you quit?					
Do you drink alcohol?	☐ Yes	☐ No	If yes, type/amount/how long?		
Do you use recreational drugs?	☐ Yes	☐ No	If yes, type/amount/how long?		
Have you been exposed to HIV?	☐ Yes	☐ No	Have you been exposed to any other sexually transmitted disease?	☐ Yes	☐ No

HOBBIES/RECREATION/SPORT

Please mark all boxes that most accurately apply to you.

☐ Card playing ☐ Golf ☐ Team sports ☐ Flying ☐ Swimming ☐ Scuba Diving ☐ Boating ☐ Fishing ☐ Gardening ☐ Photography ☐ Crafts ☐ Sewing ☐ Hunting ☐ Video games ☐ Skiing ☐ Music ☐ Dancing ☐ Other outdoor activities ☐ Other______

How did you hear about us? ☐ Insurance Company ☐ Social media ☐ Community Event ☐ Friend ☐ Relative ☐ Other

If friend/relative, who may we thank for the referral? ______

Family members seen at Inland Eye Care ______