MR # _____

Hollingshead Eye Center, P.C.℠

SurgiCare Center of Idaho

HOLLINGSHEAD EYE CENTER - GENERAL MEDICAL HISTORY

Name: _____ Date of Birth: _____ Today's Date: _____

Age: _____ Height: _____ Weight: _____ Sex: ☐ M ☐ F ☐ O Pharmacy & location: _____

Primary Care Physician: _____ Optometrist: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

PERSONAL MEDICAL HISTORY – Please mark if you have ever been diagnosed with or are currently being treated with medications for the following medical conditions:

☐ Anxiety
☐ Asthma
☐ GI Problems
☐ Atrial Fibrillation
☐ Back Problems
☐ Bleeding Disorder
☐ Bronchitis
☐ Cancer: _____
☐ Chest pain / Angina
☐ Congestive Heart Failure
☐ COPD
☐ Depression
☐ Diabetes (type) _____
Recent HbA1c _____
☐ Emphysema
☐ OTHER _____

☐ ENT Problems
☐ Neck Problems
☐ HIV / AIDS
☐ Hard of Hearing
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis: Type _____
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney / Bladder Problems
☐ Liver Disease
☐ Malignant hyperthermia
☐ MRSA
☐ Multiple Sclerosis

☐ Osteoporosis
☐ Psychiatric Problems
☐ Pacemaker
☐ Palpitations
☐ Prostate Problems
☐ Restless Leg Syndrome
☐ Seizures
☐ Shortness of Breath
☐ Sleep Apnea
CPAP use? ☐ Yes ☐ No
☐ Stroke / CVA / TIA
☐ Syphilis / Gonorrhea
☐ Urinary / Gynecological Problem
☐ VRE
☐ **NONE**

ADDITIONAL OPHTHALMIC RELATED MEDICAL HISTORY – Please mark if you have ever been diagnosed with or are currently being treated with medications for the following medical conditions:

☐ Ankylosing Spondylitis
☐ Behcet's Disease
☐ Blepharitis
☐ Cataract
☐ Crohn's Disease
☐ Corneal Scarring
☐ Dry Eye Syndrome
☐ Eczema
☐ Other Autoimmune Disease _____

☐ Glaucoma
☐ Grave's Disease
☐ Hashimoto's Disease
☐ Herpes Simplex (Cold Sores)
☐ Herpes Zoster (Shingles)
☐ Keloid Disorder
☐ Keratoconus
☐ Lupus

☐ Macular Degeneration
☐ Meibomian Gland Dysfunction
☐ Retina Problems
☐ Rheumatoid Arthritis
☐ Sjogren's Syndrome
☐ Thyroid Disorder
☐ Ulcerative Colitis
☐ **NONE**

Date of last Autoimmune Condition flare up: _____

Previous Eye Surgery or Injury? ☐ Yes ☐ No (Please list any previous eye surgeries, lasers, injections, injuries, or other treatments and approximate dates)

_____

Please list all eye drops or eye medications you are currently using. Include frequency and which eye:

_____

Do you wear any of the following? ☐ Glasses (distance) ☐ Glasses (readers) ☐ Glasses (bifocals)
Do you currently have, or have ever required Prism in your glasses? ☐ Yes ☐ No
Do you currently suffer from double vision? ☐ No ☐ Yes – if so, while wearing glasses? ☐ Yes ☐ No
Do you currently wear contact lenses? ☐ No ☐ Yes: Type _____ Number of years_____
Where did you purchase your last pair of glasses / contact lenses? _____

SOCIAL HISTORY:
Do you drink alcohol? ☐Yes ☐No Drinks per week? _____
Do you smoke? ☐Yes ☐No Packs per Day? _____ How many years? _____ Former smoker? ☐Yes ☐No
Occupation: _____

FAMILY HISTORY: (Please mark any that apply below and indicate your relationship)

☐ Arthritis _____	☐ Glaucoma _____	☐ Melanoma _____
☐ Blindness _____	☐ Hypertension _____	☐ Thyroid _____
☒ Cataract _____	☐ Keratoconus _____	☐ Stroke _____
☐ Cancer _____	☐ Macular Degeneration _____	☐ Other _____

SURGICAL HISTORY: Please list **all** prior surgeries within the past 10 years to the best recollection, include approximate dates:

Procedure	**Date**
_____	_____
_____	_____
_____	_____
_____	_____

Complications with previous anesthesia / sedation?
☐ NO ☐ YES:_____

ALLERGIES (medication, food, latex & adhesives)	
☐ **NONE**	
Allergy	**Reaction**

Are you taking a blood thinner? ☐ **NO** ☐ **YES:** Reason: _____
(Aspirin, Coumadin / Warfarin, Eliquis, Plavix, Xarelto, Pradaxa)

Are you on Oxygen? ☐ **NO** ☐ **YES:** _____ **liters** **Reason:** _____

Do you have mobility restrictions? ☐ **NO** ☐ **YES - Do you use the following?** ☐ **Walker/Cane** ☐ **Wheelchair**

Are you able to lay on your back for a time period of at least 20 minutes or longer? ☐ **YES** ☐ **NO:** _____
(reason)

_____ _____/_____/_____
Patient Signature **Date**

Reviewed By: _____

Medication Reconciliation Section

Please list all current medications (including over the counter and prescription medication)

(Patient to complete section below) **(THIS SECTION IS FOR OFFICE USE ONLY)**

Medication Name	Dose	Frequency	Last taken (eye 1)	Continue meds after discharge	Last taken (eye 2)	Continue meds after discharge
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N

ALLERGIES (medication, food, latex & adhesives)			
☐ **NONE**			
Allergy	**Reaction**	**Allergy**	**Reaction**

Patient Signature: _____ Date: _____/_____/_____

FOR OFFICE USE ONLY

New Medications

Start Date (eye 1)	Start Date (eye 2)	Medication name	Dose	Instructions	Ordered	Prescriber
					Y N	**MEH RTB**
					Y N	**MEH RTB**
					Y N	**MEH RTB**
					Y N	**MEH RTB**
					Y N	**MEH RTB**

(SIGNED ON DAY OF SURGERY IF APPLICABLE)

Patient Signature:_____ Date:_____/_____/_____

Nurse Signature:_____ Date:_____/_____/_____

Physician Signature:_____ Date:_____/_____/_____

BMI: _____

NO CHANGES FOR SECOND EYE SURGERY

Patient initials:_____ Date:_____ Nurse initials: _____ Date: _____ Physician initials: _____Date: _____