PREMIER EYE CARE
OF EASTERN IDAHO
MEDICAL • SURGICAL • OPTICAL

MEDICAL HISTORY

Matthew P. Traynor, MD
Kyle G. Thompson, MD
Jason G. Hooton, MD

Patient Name____________________________ __________Date of Birth_____________________Today's Date_____ ________________

Primary Care Dr_____________________________Last eye exam___________________Performed by Dr__________________________

EYE HISTORY

EYE HISTORY	YOURSELF	FAMILY
Glaucoma	☐YES NO☐	☐YES NO☐
Cataract	☐YES NO☐	☐YES NO☐
Diabetic retinopathy	☐YES NO☐	☐YES NO☐
Macular degeneration	☐YES NO☐	☐YES NO☐
Retinal Detachment	☐YES NO☐	☐YES NO☐
Trauma to the eye	☐YES NO☐	☐YES NO☐
Poor vision since birth	☐YES NO☐	☐YES NO☐
Crossed eyes	☐YES NO☐	☐YES NO☐
Dry eyes	☐YES NO☐	☐YES NO☐

EYE SURGERY HISTORY

EYE SURGERY HISTORY	DATE
___________________________________	__________________
___________________________________	__________________
___________________________________	__________________
___________________________________	__________________
___________________________________	__________________

Do you wear glasses? ☐ YES ☐ NO

☐ Always ☐ Occasionally ☐ Reading ☐ Driving

Do you wear contacts? ☐ YES ☐ NO

Brand______________________________ Hrs/Day____________

PAST MEDICAL HISTORY

☐	Diabetes ______yrs	☐	Asthma
☐	High Cholesterol	☐	Arthritis
☐	Hypertension	☐	Cancer
☐	Thyroid disease	☐	COPD
☐	Stroke/TIA	☐	Migraines
☐	Heart Disease	☐	Seizures
☐	Hospice	☐	Dialysis

PAST SURGICAL HISTORY

PAST SURGICAL HISTORY	DATE
___________________________________	__________________
___________________________________	__________________
___________________________________	__________________
___________________________________	__________________
___________________________________	__________________
___________________________________	__________________

SOCIAL HISTORY

Do you smoke?	☐YES NO☐	FORMER ☐______yrs
Do you drink alcohol?	☐YES NO☐	frequency___________
Recent weight change?	☐YES NO☐	gain/loss__________lbs
Regular exercise?	☐YES NO☐	__________times/week

ANESTHESIA HISTORY

Have you had any complications from anesthesia? ☐YES NO/?☐

____

Ever diagnosed with malignant hyperthermia? ☐YES NO/?☐

Family members with malignant hyperthermia? ☐YES NO/?☐

REVIEW OF SYSTEMS

EAR, NOSE, AND THROAT
- HARD OF HEARING ☐
- RINGING IN EARS ☐
- VERTIGO ☐

CARDIOVASCULAR
- CHEST PAIN ☐
- DIZZINESS ☐
- FAINTING SPELLS ☐
- SHORTNESS OF BREATH ☐
- IRREGULAR HEART BEAT ☐
- DIFFICULTY LYING FLAT ☐

CONSTITUTIONAL
- FATIGUE/WEAKNESS ☐
- FEVER ☐
- WEIGHT GAIN/LOSS ☐

RESPIRATORY
- COUGH ☐
- CONGESTION ☐
- WHEEZING ☐
- ASTHMA ☐

GASTROINTESTINAL
- HEARTBURN ☐
- NAUSEA/VOMITING ☐
- JAUNDICE/HEPATITIS ☐

URINARY
- PAIN/DIFFICULTY ☐
- BLOOD IN URINE ☐
- KIDNEY STONES ☐
- HISTORY OF STD'S ☐

PSYCHIATRIC
- ANXIETY/DEPRESSION ☐
- MOOD SWINGS ☐
- DIFFICULTY SLEEPING ☐

ENDOCRINE
- INCREASED THIRST ☐
- INCREASED HUNGER ☐
- INCREASED URINATION ☐
- INCREASED SWEATING ☐
- FINGERNAIL CHANGES ☐

NEUROLOGICAL
- SEIZURES ☐
- WEAKNESS/PARALYSIS ☐
- NUMBNESS ☐
- TREMORS ☐

BLOOD/LYMPHNODES
- EASY BRUISING ☐
- GUMS BLEEDING ☐
- PROLONGED BLEEDING ☐
- HEAVY ASPIRIN USE ☐

MUSCULOSKELETAL
- STIFFNESS ☐
- ARTHRITIS ☐
- JOINT PAIN/SWELLING ☐

SKIN
- RASH/SORES ☐
- ECZEMA ☐
- LESIONS ☐
- HIVES ☐

Patient signature (please complete the back of this form before signing)

______________________________________ ________________

Patient or guardian Date

Patient Name____________________________________Date of Birth_______________ __Today's Date__________________

MEDICATION ALLERGIES Do you have any known medication allergies? ☐ YES ☐ NO

Medication/Reaction ____

____

CURRENT EYE MEDICATIONS (PRESCRIBED AND OVER THE COUNTER)

Name of medication	Eye(s)	Frequency
______________________	Right Left Both	______________
______________________	Right Left Both	______________
______________________	Right Left Both	______________
______________________	Right Left Both	______________
______________________	Right Left Both	______________
______________________	Right Left Both	______________
______________________	Right Left Both	______________
______________________	Right Left Both	______________
______________________	Right Left Both	______________
______________________	Right Left Both	______________

CURRENT MEDICATIONS (PRESCRIBED AND OVER THE COUNTER)

Name of medication	Dosage	Frequency

CHANGES IN MEDICAL CONDITION (PLEASE NOTE ANY CHANGES IN YOUR HEALTH SINCE YOUR LAST EXAM)

Medical condition, surgery, hospitalization	Date

PHYSICIAN SIGNATURE

Matthew P. Traynor, MD	Date	Kyle G. Thompson, MD	Date
Jason G. Hooton, MD	Date		Date