BoozmanHof
WORLD CLASS EYE CARE

Date: _____ MR#: _____

Health History

Patient Name: _____ Date of Birth: _____ Height: _____ Weight: _____

Does the patient have Power of Attorney Documentation? ☐ Yes ☐ No (*If yes, please provide a copy*)

Primary Care Physician (PCP): _____ Date of Last Visit: _____

PCP Clinic Name & Address: _____ Phone #: _____

Cardiologist: _____ Pulmonologist: _____ Oncologist: _____

Emergency Contact/Relationship: _____ Phone #: _____

Pharmacy/Address: _____ Phone #: _____

Respiratory

Yes No

☐ ☐ Asthma
☐ ☐ COPD/Emphysema
☐ ☐ Recent pneumonia/bronchitis
When: _____
☐ ☐ Shortness of breath
☐ ☐ Smoker (Current or Past)
☐ ☐ Oral Tobacco (Current or Past)
☐ ☐ Tuberculosis
☐ ☐ Use of oxygen
☐ As needed ☐ Continuous
☐ At night
☐ ☐ Sleep Apnea ☐ CPAP/BiPAP
☐ ☐ Pulmonary Embolism
When: _____

Cardiovascular

Yes No

☐ ☐ Chest pain or pressure When: _____
☐ ☐ Irregular heartbeat
☐ Atrial Fibrillation ☐ Other _____
☐ ☐ Heart Attack When: _____
☐ ☐ Pacemaker/Defibrillator When: _____
☐ ☐ High blood pressure
☐ ☐ Heart murmur
☐ ☐ Ankle swelling or fluid retention
☐ ☐ Vascular stents When: _____
Location in body: _____
☐ ☐ Deep Vein Thrombosis When: _____
☐ ☐ Use of blood thinners

Gastrointestinal

Yes No

☐ ☐ Hepatitis
☐ ☐ Liver Disease
☐ ☐ Use of alcohol
☐ ☐ Use of marijuana
☐ ☐ Use of illicit drugs
☐ ☐ Heartburn or GERD

Genitourinary

Yes No

☐ ☐ Kidney Disease
☐ ☐ Renal Dialysis
☐ ☐ Hemodialysis
☐ ☐ Peritoneal Dialysis
Dialysis Center: _____

Orthopedic

Yes No

☐ ☐ Trouble lying flat
☐ ☐ Muscle or joint pain
☐ ☐ Back or Neck pain

Endocrine

Yes No

☐ ☐ Diabetes
☐ ☐ Weight Loss Medication
Name of medication: _____
☐ ☐ Thyroid Disease
☐ ☐ Autoimmune Disease
☐ Lupus ☐ RA ☐ Other: _____

Neurological

Yes No

☐ ☐ Stroke or TIA Date: _____
☐ ☐ Fainting spells or passing out
When: _____
☐ ☐ Seizures When: _____
☐ ☐ Weakness, numbness, or tingling
☐ ☐ Memory problem
☐ ☐ Frequent or severe headaches
☐ ☐ Recent fall When: _____
☐ ☐ Anxiety or depression
☐ ☐ Claustrophobia

Other

Yes No

☐ ☐ Cancer Type: _____
☐ ☐ Chemo or radiation
Last treatment: _____
☐ ☐ Abnormal bleeding
(besides blood thinners)
☐ ☐ HIV/AIDS
☐ ☐ Open wounds
☐ ☐ Past problems with
Anesthesia
☐ ☐ Nausea/Vomiting
☐ ☐ Other (explain below)
☐ ☐ COVID-19 When: _____
Symptoms: _____

Comments: _____

Date: _____

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MR#: _____

Patient Name: _____ Date of Birth: _____

Medications: List all medications (including prescriptions, vitamins, over-the-counter medicines, etc.) you currently take.

Medication Name	Dosage / Strength	Route (By Mouth/Injection)	Frequency/How Often

Allergies: List all allergies and sensitivities you have had to products in the past including prescription drugs (e.g. Valium), over-the-counter medicines (e.g. Ibuprofen, eye drops), antiseptics (e.g. Betadine, Latex), etc.

Allergic Medication / Product	Allergic Reaction

Past Surgeries: List ALL surgeries/procedures you have had in the past.

Procedure	Month/Year	Surgeon