

**NAME** \_\_\_\_\_ **RACE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
**DOB** \_\_\_\_\_ **AGE** \_\_\_\_\_ **HT** \_\_\_\_\_ **WT** \_\_\_\_\_ lbs stated by patient **SEX**  Male  Female

**MEDICAL HISTORY:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> ENT Problems                    | <input type="checkbox"/> Other Psychiatric Problems           |
| <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> GI Problems                     | <input type="checkbox"/> Pacemaker                            |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Glaucoma                        | <input type="checkbox"/> Palpitations                         |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Gyn Problems                    | <input type="checkbox"/> Prostate Problems                    |
| <input type="checkbox"/> Back/Neck Problems       | <input type="checkbox"/> HIV                             | <input type="checkbox"/> Restless Leg Syndrome                |
| <input type="checkbox"/> Bleeding Disorder        | <input type="checkbox"/> Hard of Hearing                 | <input type="checkbox"/> Retina Problems                      |
| <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> Heart Attack                    | <input type="checkbox"/> Seizures                             |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Heart Disease                   | <input type="checkbox"/> Sinus Problems                       |
| <input type="checkbox"/> Chest pain               | <input type="checkbox"/> Heart Murmur                    | <input type="checkbox"/> Sleep Apnea                          |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis Type _____            | <input type="checkbox"/> Stroke                               |
| <input type="checkbox"/> COPD                     | <input type="checkbox"/> High blood pressure             | <input type="checkbox"/> Thyroid Problems                     |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> High Cholesterol                | <input type="checkbox"/> Ulcers                               |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Kidney/Bladder/Urinary Problems | <input type="checkbox"/> Any other problems of concern: _____ |
| <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Liver Disease                   | _____   |

**SURGICAL HISTORY:** (list all prior surgeries to the best recollection)

\_\_\_\_\_  
 \_\_\_\_\_

Complications with anesthesia?  Yes  No If yes, what is the complication? \_\_\_\_\_

**FAMILY HISTORY OF OCULAR DISEASE:**

- Macular Degeneration Whom: \_\_\_\_\_  
 Glaucoma Whom: \_\_\_\_\_  
 Diabetes Whom: \_\_\_\_\_

**DRUG ALLERGIES:**  No known allergies  Latex allergy  Sulfa allergy  Adhesive tape

Medication allergy \_\_\_\_\_

**PHARMACY NAME** \_\_\_\_\_ **Location** \_\_\_\_\_ **Phone** \_\_\_\_\_

**MEDICATIONS:** (Medications may be listed in the form of a patient's current list.)

Drug Name	Dosage	Times per day

If you need to add more medications, please add to the back of this form.

**SOCIAL HISTORY:**

Do you drink alcohol?  Yes  No Drinks per week? \_\_\_\_\_

Do you smoke?  Yes  No PPD \_\_\_\_\_ Years \_\_\_\_\_

Previous smoker?  Yes  No When did you quit? \_\_\_\_\_ PPD \_\_\_\_\_ Years \_\_\_\_\_