ADVANCED EYE SURGERY AND LASER CENTER
HEALTH HISTORY

DATE OF SURGERY	PATIENT NAME	AGE	SEX	BIRTH DATE	WEIGHT	HEIGHT

LIST SCHEDULED SURGERY or PROCEDURE: / /	SURGEON:
NAME OF PERSON COMPLETING FORM:	RELATIONSHIP TO PATIENT:
PHONE NUMBER:	MEDICAL DOCTOR:

DO YOU HAVE OR HAVE YOU EVER HAD: Please circle YES OR NO and answer questions completely. You may use the back of the page, if necessary to explain YES answers or if more room is needed.

1. Problems with Anesthesia? YES/NO
2. Family Problems w/Anesthesia? YES/NO
3. Do you Smoke? _____PPD YES/NO
4. Alcohol Use? >2 drinks/wk? Illegal Drug Use? YES/NO
5. Active Infection/Disease? HIV, TB, or Hepatitis C? YES/NO
6. Do you have Dentures, Bridges, Caps or Crowns? YES/NO
7. High Blood Pressure? YES/NO
8. Heart Attack or Angina, Congestive Heart Failure? YES/NO
9. Pacemaker, Stent, AICD or other cardiac implant? YES/NO
10. Irregular heartbeat? YES/NO
11. Where and when was your last EKG? _____
12. Emphysema? COPD? YES/NO
13. Asthma? Last attack _____ YES/NO
14. Shortness of Breath? (at rest or exercising) YES/NO
15. Sleep Apnea? CPAP? YES/NO YES/NO
16. Seizure or Epilepsy? YES/NO
17. Stroke or TIA? YES/NO
18. Special Positioning Needs? YES/NO
19. Language/Communication Needs? YES/NO
    Alzheimers? Dementia? Mental Retardation?
20. Diabetes (Tx. Insulin-Oral-Diet)? YES/NO
21. Liver Problems? YES/NO
22. Kidney Disease requiring Dialysis? YES/NO
23. Thyroid Disease/Goiter? YES/NO
24. Sickle Cell Disease/Trait? YES/NO
25. Bleeding/Clotting Problems? YES/NO
26. Cancer or Leukemia/Lymphoma? YES/NO

SURGERIES

27. Pregnancy Possible/LMP _____? YES/NO
28. Stomach ulcer, PUD? YES/NO
29. GERD? Hiatal Hernia? YES/NO
30. Glaucoma, retinal problems, Macular Degeneration or other? _____ YES/NO
31. Contact Lens or Glasses? YES/NO
32. Hearing Aid? YES/NO

Please list all of the surgeries you have had.

_____
_____
_____
_____
_____
_____

COMMENTS:

_____
_____
_____
_____

Drug Allergies & Reactions/Sensitivities YES/NO

If yes, please list: _____
_____
_____
_____

Allergic to latex? YES/NO If yes, reaction? _____

Please complete attached patient medication sheet.
(Please let us know if you are taking Flomax or Cardura)

_____ _____

FAMILY HISTORY-This is history of **immediate family**. Please list relationship to patient:

Disease		Relationship to patient
Blindness	YES/NO	_____
Cataract	YES/NO	_____
Glaucoma	YES/NO	_____
Macular Degeneration	YES/NO	_____
Retinal Detachment	YES/NO	_____
Arthritis	YES/NO	_____
Cancer	YES/NO	_____
Diabetes	YES/NO	_____
Heart Attack/Disease	YES/NO	_____
High Blood Pressure	YES/NO	_____
Kidney Disease	YES/NO	_____
Stroke	YES/NO	_____
Thyroid Disease	YES/NO	_____
Lung Disease	YES/NO	_____

SOCIAL HISTORY

Marital Status: S M W D Occupation: _____

FOR OFFICE USE ONLY:

HISTORY REVIEWED
SURGEONS SIGNATURE:

_____ DATE: _____
_____ DATE: _____
_____ DATE: _____
_____ DATE: _____

ANESTHESIOLOGIST SIGNATURE:

_____ DATE: _____
_____ DATE: _____
_____ DATE: _____
_____ DATE: _____

PATIENT LABEL

ADVANCED EYE SURGERY & LASER CENTER

PATIENT MEDICATION LIST

Patient Name _____ **Date of Birth** _____

Source of Medication List:

Date of Surgery _____ _ □ List/Bottles □ MD Office _____

□ Pt/Family Recall □ Other _____

Allergies/Sensitivities (list all allergies, including food, latex and medication. PLEASE INCLUDE REACTIONS TO ITEMS YOU LIST AS ALLERGIES, (i.e. rash, fever, nausea/vomiting, etc.)

_____

_____

_____

Please list all medications you currently take, including vitamins, herbal supplements, antacids, or other OTC (over the counter) medicines. Include Oxygen therapy and respiratory treatment meds.

*******PLEASE LET US KNOW IF YOU ARE TAKING;**

- FLOMAX, CARDURA, HYTRIN, UROXATROL,RAPAFLO or MINIPRIS*****

TODAY'S DATE	NAME OF MEDICATION/VITAMINS/ HERBAL SUPPLEMENTS/ETC.	DOSE	METHOD & FREQUENCY TAKEN (1 pill once a day, 1 injection twice a day, etc.)	PRESCRIBING PHYSICIAN

DO NOT FILL OUT BELOW THIS LINE. FOR OFFICE USE ONLY

□ **PATIENT IS NOT ON ANY MEDICATIONS**

DATE_____

REASON UNABLE TO ATTAIN _____

PHYSICIAN/AESLC NOT RESPONSIBLE FOR THE ACCURACY OF PATIENT REPORTED INFORMATION.

□ **No Changes to Current Medications**

□ New/Changed Medications for Home (Nurse to Complete) Dose Route Frequency/Indication	Medication Info Provided
	□
	□
	□

_____ _____ _____ _____

Patient/Patient Representative Signature Date Time Nurse Signature

*****This is an updated medication list. Please take this to your next physician visit.**

PATIENT LABEL