Patient Name: _____ Chart Number: _____

Eye Plastic Surgery Associates – Health History

Current Medical Conditions:

Please check any of the following that apply.

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ OTHER:_____ _____ _____

Past Surgeries:

Have you had any of the following surgeries? Please check any that apply.

- ☐ **Appendix**
- ☐ **Bladder**
- ☐ **Breast**
  - ☐ Lumpectomy (Right, Left, or Both)
  - ☐ Mastectomy (Right, Left, or Both)
- ☐ **Colon**
- ☐ **Gallbladder**
- ☐ **Heart**
  - ☐ Coronary artery Bypass
  - ☐ Transplant
  - ☐ Valve Replacement
- ☐ **Hip** (Right, Left, or Both)
- ☐ **Knee** (Right, Left, or Both)
- ☐ **Kidney**
- ☐ **Liver**
- ☐ **Ovaries**
- ☐ **Pancreas**
- ☐ **Prostate**
  - ☐ Cancer
  - ☐ TURP
- ☐ **Skin**
  - ☐ Basal Cell Carcinoma
  - ☐ Melanoma
  - ☐ Skin Biopsy
  - ☐ Squamous Cell Carcinoma
- ☐ **Spleen**
- ☐ **Testicles**
- ☐ **Uterus**
  - ☐ Fibroids
  - ☐ Uterine Cancer
  - ☐ Cervical Cancer
- ☐ OTHER: _____ _____ _____

Ocular History:

Please check any that apply and **CIRCLE** which eye it applies to.

- ☐ Allergic Conjunctivitis
- ☐ **Blepharitis**
- ☐ **Cataract** (Right, Left, Both)
- ☐ **Contact Lenses**
- ☐ **Corneal Dystrophy** (Right, Left, Both)
- ☐ **Diabetic Retinopathy** (Right, Left, Both)
- ☐ **Dry Eyes**
- ☐ **Glasses**
- ☐ **Glaucoma** (Right, Left, Both)
- ☐ **Macular Degeneration** (Right, Left, Both)
- ☐ **Macular ERM** (Right, Left Both)
- ☐ **Narrow Angles** (Right, Left, Both)
- ☐ **Ocular Hypertension** (Right, Left, Both)
- ☐ **Ophthalmic Migraine**
- ☐ **Pseudoexfoliation**
- ☐ **Retinal Tear** (Right, Left, Both)
- ☐ **Strabismus**
- ☐ **PVD** (Right, Left, Both)
- ☐ **Vitreous Floaters** (Right, Left, Both)

Ocular Surgery:

Please check any that apply and **CIRCLE** which eye you had the surgery on.

- ☐ **Blepharoplasty** (Right, Left, Both)
- ☐ **Cataract Surgery** (Right, Left, Both)
- ☐ **Corneal Transplant** (Right, Left, Both)
- ☐ **DSAEK** (Right, Left, Both)
- ☐ **Eye Muscle Surgery**
- ☐ **Intravitreal Injections** (Right, Left, Both)
- ☐ **Lasik** (Right, Left, Both)
- ☐ **LPI** (Right, Left, Both)
- ☐ **LTP** (Right, Left, Both)
- ☐ **PRK** (Right, Left, Both)
- ☐ **Ptosis Repair** (Right, Left, Both)
- ☐ **Punctal Plugs** (Right, Left, Both)
- ☐ **Strabismus Surgery**
- ☐ **Retinal Laser** (Right, Left, Both)
- ☐ **Trabeculectomy** (Right, Left, Both)
- ☐ **Tube Shunt** (Right, Left, Both)

Patient Name: _____ Chart Number: _____

Eye Plastic Surgery Associates – Health History

Please list which medications you are on, the dosage, and frequency.

Name of Medication:	**Dosage:**	**Frequency:**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Allergies:

Please list any drug allergies.

1. _____
2. _____
3. _____
4. _____

Are you allergic to latex gloves? YES NO

Social History

Marital Status:	Single	Married	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily
Use of Tobacco:	YES	NO	How often? _____	
Caffeine Intake:	Never	Rarely	Moderate	Daily
How often do you exercise?	Never	Daily	Once a week	A few times a month

X_____ _____

Patient Signature, Parent, or Guardian **Date**