Oculofacial
Plastic and Reconstructive Surgery, Inc.

MEDICAL HISTORY

PLEASE PRINT

Patient's Name _____ Date _____

Primary Care Physician's Name_____

Date of last visit to your Primary Care Physician? _____

What is your estimate of your general health? ☐ Poor ☐ Fair ☐ Good

Eye Physician's Name _____

Approximate date of last eye exam? _____

Do you wear glasses? Yes ☐ / No ☐ Do they contain prisms? Yes ☐ / No ☐

Do you wear Contact Lenses? Yes ☐ / No ☐ Soft ☐ / RGP ☐ Date started wearing CL _____ # of hrs worn/day_____

Approximate hours of computer use per day? _____

Hobbies or special visual needs: _____

What is the chief complaint or reason for your visit with our office? _____

HAVE YOU EVER HAD THE FOLLOWING (Please Check)

Allergic Reaction to:		Liver Disease	☐ YES ☐ NO
Penicillin or Other Antibiotic	☐ YES ☐ NO	Hepatitis or Jaundice	☐ YES ☐ NO
Aspirin or Ibuprofen	☐ YES ☐ NO	Kidney Disease	☐ YES ☐ NO
Any Eye Drops: _____	☐ YES ☐ NO	Thyroid or parathyroid Problems	☐ YES ☐ NO
Anesthetics or Sedatives	☐ YES ☐ NO	Graves Disease	☐ YES ☐ NO
Latex	☐ YES ☐ NO	Ulcers	☐ YES ☐ NO
Other Medication: _____	☐ YES ☐ NO	Digestive Disorders / Acid Reflux	☐ YES ☐ NO
Heart Murmur	☐ YES ☐ NO	Diabetes (Insulin / Diet Controlled)	☐ YES ☐ NO
Antibiotics before Medical or Dental Procedure	☐ YES ☐ NO	Arthritis	☐ YES ☐ NO
Artificial Heart Valve	☐ YES ☐ NO	Artificial Joints (Hips, Knees, etc.)	☐ YES ☐ NO
Heart (Surgery, Disease, Attack, Arrhythmia)	☐ YES ☐ NO	Head or Neck Injuries	☐ YES ☐ NO
Rheumatic Fever	☐ YES ☐ NO	Epilepsy, Convulsions (Seizures)	☐ YES ☐ NO
Heart Pacemaker	☐ YES ☐ NO	Viral Infections	☐ YES ☐ NO
High Blood Pressure / Usual BP :_____	☐ YES ☐ NO	Cold Sores / Fever Blisters	☐ YES ☐ NO
Low Blood Pressure	☐ YES ☐ NO	AIDS or HIV infection	☐ YES ☐ NO
Stroke	☐ YES ☐ NO	Sexually Transmitted Disease	☐ YES ☐ NO
Anemia or Other Blood Disorder	☐ YES ☐ NO	Cortisone Medication	☐ YES ☐ NO
Prolonged Bleeding due to a cut	☐ YES ☐ NO	Cancer – Type: _____	☐ YES ☐ NO
Lung or Breathing Problems	☐ YES ☐ NO	Chemotherapy	☐ YES ☐ NO
Tuberculosis	☐ YES ☐ NO	Radiation Therapy	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Emotional Problems	☐ YES ☐ NO
Hives or Skin Rash	☐ YES ☐ NO	Psychiatric Treatment	☐ YES ☐ NO
Persistent Cough	☐ YES ☐ NO	Alcohol / Drug Dependency	☐ YES ☐ NO
Sinus Problems	☐ YES ☐ NO	Hearing Problems	☐ YES ☐ NO
Multiple Sclerosis	☐ YES ☐ NO	Appetite Changes	☐ YES ☐ NO
Sleep Apnea	☐ YES ☐ NO	Unexplained Weight Loss or Gain	☐ YES ☐ NO

ARE YOU (Please check)

Presently being treated for any illness	☐ YES ☐ NO	Considered a touchy person	☐ YES ☐ NO
Aware of any change in your health	☐ YES ☐ NO	Easily upset or irritated	☐ YES ☐ NO
Often exhausted or fatigued	☐ YES ☐ NO	Often unhappy or depressed	☐ YES ☐ NO
Having difficulty sleeping	☐ YES ☐ NO	Female – Taking birth control pills	☐ YES ☐ NO
Having night sweats	☐ YES ☐ NO	Female – Pregnant	☐ YES ☐ NO
A smoker – packs per day / week: _____	☐ YES ☐ NO	Female – Nursing	☐ YES ☐ NO

(Continued on other side)

MEDICAL HISTORY (cont)

DO YOU HAVE A HISTORY OF (Please Check)					
Eyelid Disease or Surgery	☐ RIGHT EYE	☐ LEFT EYE	Cornea Disease or Surgery	☐ RIGHT EYE	☐ LEFT EYE
*Complications:*_____			*Complications:*_____		
Tear Duct Surgery	☐ RIGHT EYE	☐ LEFT EYE	Retina / Macula Disease or Surgery	☐ RIGHT EYE	☐ LEFT EYE
*Complications:*_____			*Complications:*_____		
Dry Eyes	☐ RIGHT EYE	☐ LEFT EYE	Eye Infection or Injury	☐ RIGHT EYE	☐ LEFT EYE
*Complications:*_____			*Complications:*_____		
Cataracts or Cataract Surgery	☐ RIGHT EYE	☐ LEFT EYE	Family Eye Disease	☐ RIGHT EYE	☐ LEFT EYE
*Complications:*_____			*Complications:*_____		
Glaucoma or Glaucoma Surgery	☐ RIGHT EYE	☐ LEFT EYE	Other: _____	☐ RIGHT EYE	☐ LEFT EYE
*Complications:*_____			_____		

PLEASE COMPLETE

Please list any previous surgeries or hospitalizations: _____
_____
_____
_____
_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your treatment with us:
_____
_____
_____
_____

List any medications, eye medications, herbal supplements, and/or vitamins taken within the last 14 days: _____
_____
_____
_____
_____

Do you have any problems with your skin or complexion? _____
_____
_____
_____

AUTHORIZATION

Please advise us in the future of any change in your medical history or any medication that you may be taking.

I understand the above information is necessary to provide me with care in a safe and effective manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

Patient Signature: _____ Date _____

FOR DOCTOR'S USE ONLY

Doctor's remarks:_____
_____
_____
_____
_____