

## OPHTHALMIC PLASTIC SURGERY MEDICAL HISTORY

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Date \_\_\_\_\_

Name of physician referring you \_\_\_\_\_

Why did the physician refer you? \_\_\_\_\_

**C.C. and P.I. (For Physician use only)**

**REVIEW OF SYSTEMS**

Do you currently have any problems in the following areas? If YES, provide information.

	YES	NO	EXPLANATION OF PROBLEM (Date of Onset)
<b>Skin</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rash, nodules, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Eyes</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Distorted vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Redness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excess tearing / watering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic infection of eye or lid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy or crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Halos around lights	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Droopy eye lids	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Ears, nose, mouth, throat</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sinus, congestion, runny nose	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic cough, recent cold	<input type="checkbox"/>	<input type="checkbox"/>	_____

Name \_\_\_\_\_

	YES	NO	EXPLANATION OF PROBLEM (Date of Onset)
<b>Respiratory (Lungs / breathing)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma, emphysema, coughing	<input type="checkbox"/>	<input type="checkbox"/>	_____
blood, tuberculosis, any lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Cardiovascular (Heart / Blood vessels)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest pain, increased blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
heart attack, irregular heart beat, heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Gastrointestinal (Stomach / Intestines)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcers, blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Genitourinary</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitals, kidney, bladder, prostate, stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>OBGYN</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer, lumps in breast, abnormal menstrual periods	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Bones, joints, muscles</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle or joint pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Neurologic system</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions, stroke, paralysis, headaches, migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Lymphatics (Lymph nodes, swelling)</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Blood</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia, clots, excess bleeding, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Allergic / immunologic</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay fever symptoms, other allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Psychiatric</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Diabetes</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Thyroid</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list any other conditions for which you have been under medical care \_\_\_\_\_

**PAST HISTORY**

List all surgeries, including eye surgeries, and date of each.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

Any problems with anesthetics (local or general)?  YES  NO

If YES, please describe \_\_\_\_\_

**HISTORY AND REVIEW OF SYMPTOMS (2)**

Name \_\_\_\_\_

List all medications, vitamins, supplements (Use Separate Sheet As Necessary)

List all prescribed medications, how often medications are used, and dosage

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_

List all vitamins

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

List all supplements

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

List all herbs

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

Are you allergic to any medications?  YES  NO

If YES, list medications \_\_\_\_\_

Are you allergic to latex?  YES  NO

**FAMILY HISTORY Do any family members have the following?**

DISEASE	YES	NO	EXPLANATION OF PROBLEM / WHAT FAMILY MEMBER? <i>Example: Mother, Father, Sister, Brother</i>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Corneal disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy or crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any inherited disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

