PATIENT MEDICAL INFORMATION

MARIETTA EYE CLINIC

The Following information is needed by your Physician to provide the best type of care for you.

Patient Name _____ Birth Date ____/____/____ Age _____

Daytime Phone Number (_____)_____-_____ Alternate Number (_____)_____-_____

Emergency Contact Person with different phone number **Name** _____

Phone (_____)_____-_____

Does the Patient live in a **Nursing Facility**? If so, which Facility? **Name** _____

Phone (_____)_____-_____

Primary Physician Name _____ Phone _____ Last Seen _____

Cardiologist Name _____ Phone _____ Last Seen _____

Pulmonologist / Neurologist _____ Phone _____

Pharmacy Name _____ Phone _____

Patient Height _____ **Weight** _____ Any body piercings? (Location) _____

Allergies / Sensitivities Reactions **Latex Allergy?** Yes / No

_____ _____ Reaction _____

_____ _____

_____ _____

_____ _____

Ocular History: Have you ever been treated for the following:

Y N Cataract Y N Cornea Problem Y N Retinal Tear or Detachment

Y N Glaucoma Y N Diabetic Eye Disease Y N Eye Muscle Problems

Y N Eye Trauma or Injury

Any other eye problems: _____ **Do you wear:** Glasses Contact Lenses

Current Medications including vitamins, herbal supplements, over-the-counter medications, etc.

Please add dosage and frequency.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you taking aspirin or blood thinners? Yes / No Last date taken _____

Are you taking any diet/appetite suppressants medications? Yes / No Last date taken _____

SOCIAL HISTORY

Smoke No / Yes _____ packs per day for _____ years I quit _____ years ago

Drink No / Yes How much? _____

Illegal or Prescription Drug Abuse No / Yes Which drug? _____

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Patient Name _____

MEDICAL HISTORY Do you have or have you had: (If you circle "Yes", please explain)

Patient

Yes No **Problems with Anesthesia?** _____

Yes No TMJ/difficult IV stick/slow to awaken from anesthesia?

Yes No Is it difficult for you to walk up 2 flights of steps without feeling short of breath?

Yes No Is it difficult for you to lie down flat for 30 minutes without feeling short of breath?

Yes No **Cardiac Disease?** heart attack/heart murmur/heart valve/CABG/stent/pacemaker A-fib/palpitations _____

Pacemaker: Date _____ CABG: Date _____

Yes No Cardiac Stents: Date _____ Valve Replacement: Date _____

Yes No Chest pains/angina/congestive heart failure/swelling to lower extremities?

_____

Yes No **High blood pressure?** _____ Controlled on medication? _____

Yes No **Diabetes?** _____ Average am fasting blood sugar _____

Yes No **Lung disease/COPD?** shortness of breath or chronic cough? _____

Yes No Do you use **oxygen**/How often? _____

Yes No Asthma/wheezing? Date of last attack: _____

Yes No Sleep apnea? _____ Do you use CPAP? _____

Yes No Do you have any broken facial bones (nose or jaw)? _____

Yes No Do you have dentures/bridges/loose teeth/caps/crowns _____

Yes No Do you have problems hearing? Wear a hearing aid? _____

Yes No Do you have any surgical implants or prosthesis? _____

Yes No Thyroid disease? _____

Yes No Ulcer/hiatal hernia/reflux or heartburn? _____

Yes No Liver disease/jaundice/cirrhosis/other? _____

Yes No Infectious Disease: Hepatitis/HIV/TB/C-diff/MRSA _____

Yes No **Stroke/TIA/paralysis?** _____ **Date:** _____

Yes No Seizures/epilepsy? Date of last seizure: _____

Yes No Tremors/Parkinson's Disease? _____

Yes No Arthritis/joint pain/chronic back pain? _____

Yes No Bladder/Prostate problems? _____

Yes No **Kidney disease/dialysis?** _____ What days? _____

Yes No Anemia/Blood Transfusion? When _____

Yes No Sickle Cell disease or Trait? _____

Yes No Are you or could you be pregnant? _____

Yes No Have you had previous surgery? Including Eye surgery (please list) _____

_____

Yes No Have you ever been diagnosed with HIV, AIDs, HEP B, C or A or any other type of infectious disease? _____

Yes No Do you have other health concerns? _____

Yes No **Have you been sick or in the hospital in the last 30 days?** _____

_____

Pediatric Patients: (additional questions)

Yes No Born Full term? _____

Yes No Did your child spend any time in the ICU when born? _____

Yes No Meeting all developmental milestones for age? _____

Yes No Has your child ever been evaluated by a cardiologist or pulmonologist for any reason?

_____

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Patient Name _____

FAMILY HISTORY

Has anyone in your immediate family been treated for the following (If yes, please indicate relationship)

Yes No Diabetes? _____
Yes No High Blood Pressure? _____
Yes No Heart Disease? _____
Yes No Stroke? _____
Yes No Cancer? _____ Type: _____

Yes No Glaucoma? _____
Yes No Macular Degeneration? _____
Yes No Retinal Detachment? _____
Yes No Blindness? _____

Please circle "Y" if you have had any of these conditions in the last few weeks.

Constitutional Y N Fatigue Y N Fever Y N Night Sweats Y N Weakness Y N Weight Loss Y N Weight Gain	**Cardiovascular** Y N Arrhythmia Y N Calf Pain Y N Irregular Heartbeat Y N Palpitations Y N Chest pain Y N Fluid Retention Y N Leg Swelling	**Metabolic/Endocrine** Y N Cold Intolerance Y N Heat Intolerance Y N Increased Thirst Y N Increased Hunger Y N Increased Urination Y N Low Blood Sugar	**Integumentary** Y N Abnormal Hair Y N Dry Skin Y N Hives Y N Itching Skin Y N Nail Changes Y N Rash Y N Skin Lesion
HEENT Y N Exophthalmos Y N Hoarseness Y N Hearing Loss Y N Sinus Problems Y N Sore Throat Y N Ringing in Ears Y N Vertigo	**Gastrointestinal** Y N Decreased Appetite Y N Abdominal Pain Y N Constipation Y N Diarrhea Y N Heartburn Y N Nausea	**Neurological** Y N Balance Disturbance Y N Dizziness Y N Focal Weakness Y N Headache Y N Memory Difficulty Y N Numbness/Tingling	**Musculoskeletal** Y N Back Pain Y N Fracture Y N Painful Joints Y N Gait Disturbance Y N Joint Swelling Y N Muscle Weakness Y N Muscle Cramping
Respiratory Y N Asthma Y N Cough Y N Coughing Blood Y N Difficulty Breathing Y N Diff Breath / exertion Y N Wheezing	**Genitourinary** Y N Painful Urination Y N Frequent Urination Y N Urgency Y N Trouble Urinating	**Psychiatric** Y N Depression Y N Emotional Changes Y N Frequent Nightmares Y N Hallucinations Y N Nervousness Y N Anxiety Y N Insomnia	**Hematologic/Immunologic** Y N Bleeding Y N Bruising Y N Tender Lymph Node Y N Environmental Allergies Y N Food Allergies Y N Seasonal Allergies

Signature of Patient: X _____ Date: _____

PATIENTS: DO NOT FILL OUT INFORMATION BELOW. THIS IS FOR PHYSICIANS USE ONLY

Other Findings: _____

_____

Date updated with patient _____ Tech/Nurse sig _____
Date updated with patient _____ Tech/Nurse sig _____
Date updated with patient _____ Tech/Nurse sig _____

HISTORY REVIEW

Reviewed By: _____,RN/LPN Date _____ Time: _____ am/pm
Reviewed By: _____, MD - Surgeon/Anesthesiologist Date _____ Time: _____ am/pm
Reviewed By: _____,RN/LPN Date _____ Time: _____ am/pm
Reviewed By: _____, MD - Surgeon/Anesthesiologist Date _____ Time: _____ am/pm