# 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 _____

Primary parent/guardian name _____

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?

**Facility name** _____ **Facility phone** (_____) _____-_____

Referring doctor for this visit _____

Do you need a letter sent to your referring doctor? Yes No (Circle One)

**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 _____

_____ _____

**Current medications, including vitamins, herbal supplements, and over-the-counter medications**

Please include dosage and frequency.

_____ _____ _____

_____ _____ _____

_____ _____ _____

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

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

**SOCIAL HISTORY**

**Smoke** No / Yes How much? _____ I quit ____ years ago.

**Drink** No / Yes How much? _____

**Illegal or prescription drug abuse** No / Yes Which drug? _____

**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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MARIETTA EYE CLINIC

**Patient Name** _____

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

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 a.m. 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 Do you have other health concerns? _____
Yes No **Have you been sick or in the hospital in the last 30 days?** _____
Yes No Have you fallen in the past year? _____
Yes No Do you feel unsteady when standing or walking? _____
Yes No Do you use any assistive devices to walk? _____
Yes No Are you able to transfer from wheelchair to stretcher with minimal assistance?

* Be advised if you have an uncontrolled high blood pressure the day of surgery, the anesthesiologist may cancel your surgery.

** Be advised if your blood sugar is above 275 the day of surgery your surgery will be cancelled.

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MARIETTA EYE CLINIC

**Patient Name** _____

**Ocular History:** Have you ever been diagnosed with any of the following?

Y N Retinal Tear or Detachment  Y N Cataract  Y N Cornea Problem
Y N Glaucoma  Y N Diabetic Eye Disease  Y N Eye Trauma or Injury
Y N Eye Muscle Problems

**Any other eye problems:**

**Do you wear:** Glasses Contact Lenses

**FAMILY HISTORY**

Has anyone in your immediate family been diagnosed with 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:** _____ **Date:** _____