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 _____

Cell Phone Number (_____)_____-_____ Home Number (_____)_____-_____

Email Address _____

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 Name _____ **Phone** (_____)_____-_____

Last Seen _____

Neurologist Name _____ **Phone** (_____)_____-_____

Last Seen _____

Pharmacy Name _____ **Phone** (_____)_____-_____

Address _____

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

Any other eye surgeries? _____

_____

_____

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Patient Name _____ **DOB** _____

CURRENT MEDICATIONS including vitamins, herbal supplements, over-the-counter medications, etc.

Please add dosage and frequency.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

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

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

Drink? Yes ☐ No ☐ How much? _____

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

MEDICAL HISTORY Do you have or have you had: (If you mark "yes," please explain)

PATIENT

CARDIAC DISEASE

☐ YES ☐ NO **Implantable cardioverter-defibrillator (AICD)?**

☐ YES ☐ NO **STENTS? DATE:** _____

"Yes" to following require cardiology notes:

☐ YES ☐ NO **A-FIB/PALPITATIONS?**

☐ YES ☐ NO **Pacemaker? Date:** _____ **Cardiac Bypass? (CABG) Date:** _____

☐ YES ☐ NO **Chest pains/angina/congestive heart failure/swelling to lower extremities?**

(Circle all that apply)

☐ YES ☐ NO Can you walk up 2 flights of steps without feeling short of breath?

☐ YES ☐ NO Can you lie down flat for 30 minutes without feeling short of breath?

☐ YES ☐ NO High blood pressure?

☐ YES ☐ NO Are you taking aspirin or blood thinners?

PULMONARY DISEASE

☐ YES ☐ NO **HOME OXYGEN?**

☐ YES ☐ NO **COPD?**

☐ YES ☐ NO Asthma/Wheezing? **(Circle all that apply)**

Date of last attack: _____

☐ YES ☐ NO Chronic Cough?

☐ YES ☐ NO Sleep Apnea? YES ☐ NO ☐ Do you use CPAP?

PATIENT MEDICAL INFORMATION

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Patient Name _____ **DOB** _____

MEDICAL HISTORY Do you have or have you had: (If you mark "yes," please explain) cont.

PATIENT

NEUROLOGICAL

☐ YES ☐ NO **STROKE? Date:** _____

☐ YES ☐ NO **TIA? Date:** _____

☐ YES ☐ NO Seizures/eplipesy? **(Circle all that apply)** Date of last seizure: _____

☐ YES ☐ NO Tremors/Parkinson's Disease? **(Circle all that apply)**

ENDOCRINE

☐ YES ☐ NO Do you have diabetes?

☐ YES ☐ NO Do you require insulin?

What was your last A1C level? _____

☐ YES ☐ NO Thyroid Disease?

*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.

KIDNEY DISEASE

☐ YES ☐ NO Kidney Disease? Stage _____

☐ YES ☐ NO Dialysis? What days? _____

LIVER DISEASE

☐ YES ☐ NO Liver Disease/Cirrhosis? **(Circle all that apply)**

☐ YES ☐ NO Anemia/Blood Transfusion? **(Circle all that apply)** When? _____

☐ YES ☐ NO Sickle Cell Disease or Trait?

☐ YES ☐ NO Do you have a history of blood clots or a bleeding disorder?

ANESTHESIA

☐ YES ☐ NO Problems with anesthesia?

☐ YES ☐ NO TMJ?

☐ YES ☐ NO Difficult IV start?

☐ YES ☐ NO Slow to wake up from anesthesia?

☐ YES ☐ NO Ulcer/Hiatal Hernia/Reflux or Heartburn? (Circle all that apply)

☐ YES ☐ NO Any broken facial bones (nose or jaw)?

☐ YES ☐ NO Dentures/bridges/loose teeth caps/crowns? (Circle all that apply)

☐ YES ☐ NO Could you be pregnant?

☐ YES ☐ NO List previous surgeries: _____

_____

_____

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INFECTIOUS DISEASE

☐YES ☐NO Ever been diagnosed with HIV, AIDS, HEPATITIS, TB, C-DIFF/MRSA? (active MRSA not ASC candidate)

☐YES ☐NO Have you completed your COVID vaccination(s)? Date of last injection _____

OTHER

☐YES ☐NO Do you have any surgical implants or prosthesis?

☐YES ☐NO Arthritis? Chronic back pain?

☐YES ☐NO Do you have other health concerns?

☐YES ☐NO **Sick or hospitalized in the last 30 days? (need hospital notes)**

☐YES ☐NO Do you feel unsteady when standing or walking?

☐YES ☐NO Do you use assistive devices to walk?

☐YES ☐NO Are you able to transfer from wheelchair to stretcher with minimal assistance?

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, a pulmonologist, or a neurologist for any reason?

Signature of Patient: X _____ Date: _____

Signature of Primary Parent/Guardian: 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