AESTHETIC EYE, PC

OCULOFACIAL PLASTIC &
RECONSTRUCTIVE SURGERY

Print Form

Patient History

Name:_____

Reason for visit: ☒ **Right Eye** ☐ **Left Eye** ☐ **Both Eyes**_____

Symptoms:_____

How long has the problem persisted? _____ **Previous Treatment:** ☒ **Yes** ☐ **No**

Do any of the following pertain to your health?

	No	Yes	Explain
Bleeding/ scarring tendency	☒	☐	
Diabetes	☒	☐	
Heart disease	☒	☐	
High blood pressure	☒	☐	
High cholesterol	☒	☐	
Migraines or headaches (circle one)	☒	☐	
History of Cancer	☒	☐	Where:
Stroke	☒	☐	
Thyroid problems	☒	☐	☒ Hypo- or ☐ Hyper- How long?: yrs:
HIV	☒	☐	
Liver problems/ disease (hepatitis, cirrhosis, etc.)	☒	☐	
Pregnant	☒	☐	
Mental Illness (depression, anxiety, schizophrenia, etc.)	☒	☐	
Pulmonary hypertension	☒	☐	

FAMILY HISTORY

	No	Yes	Immediate Family Member
Malignant Hyperthermia	☒	☐	
Abnormal bleeding	☒	☐	
Abnormal clotting	☒	☐	
Anesthesia problems	☒	☐	
Thyroid disorders	☒	☐	

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Heart disease	☐	☐	
Macular degeneration	☒	☐	

Social History

	No	Yes	Explain
Smoke	☒	☐	☐ **Quit When? Packs/ day**
Alcohol	☒	☐	☒ **Occasional** ☐ **Daily** ☐ **Rarely**
Recreational Drug Use	☒	☐	☒ **Quit When?**

Allergies: _____ Pharmacy:_____

Medications (or may we copy your list?). This includes over-the-counter and natural supplements.

Do you have a history of any of the following?

	No	Yes	Explain
Chest pain	☒	☐	
Heart attack	☒	☐	
Irregular heartbeat	☒	☐	
Pacemaker	☒	☐	
Epilepsy or seizures	☒	☐	
Fainting, fever or chills	☒	☐	
Nausea, vomiting or diarrhea when taking antibiotics	☒	☐	
Unexpected weight loss or weight gain (circle one)	☒	☐	
Sinus disorder	☒	☐	

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Do you have a history of any of the following?

	No	Yes	Explain
Stomach absorptive disorder/ ulcers (circle one)	☒	☐	
Bladder/ kidney problems or frequency/ burning with urination (circle one)	☒	☐	
Currently breast feeding	☒	☐	
Anemia	☒	☐	Blood transfusion(s)?
Blood clots	☒	☐	
Joint pain or artificial joints (circle one)	☒	☐	
Limited motion in joints/ muscle weakness (circle one)	☒	☐	
Paralysis	☒	☐	
Numbness or tingling	☒	☐	
Attention Deficit Disorder/ Depression/ Other Mental Illness (circle one)	☒	☐	Explain:
Asthma, emphysema, bronchitis or tuberculosis (circle one)	☒	☐	
Shortness of breath/ wheezing	☒	☐	
Sleep apnea	☒	☐	

Surgeries (including any procedures of the eye)

Procedure	Year

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Other pertinent medical history (including laser treatments, peels, chemo, radiation, etc.):