THE Oculoplastics CENTER

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Medical History

Name: _____ Date: _____

Who referred you here today? _____
Name: _____
Address: _____
Telephone: _____

Reason(s) for visit: _____
How long has it been present? _____
How often does it happen: _____
What treatment(s) have you had before? _____

What medical problem are you being treated for? Who are your doctors?

Doctor:	Illness/Condition:	Phone

Have you had any surgeries in the past? Who was/were the surgeons?

Doctor:	Surgery:	Phone:

Do you have a pacemaker? _____yes _____No If "yes", what type? _____

What medications do you take? (Pills, ointments, vitamins, eye drops)

_____

_____

Do you take aspirin containing products/medications? _____yes _____No

Allergies: _____None _____Penicillin _____Sulfa _____Fluorecein _____Idoine dyes _____Shellfish

_____Latex _____Maxitrol _____Erythromycin _____Neomycin Other, Describe: _____

Type of reaction: _____

Past Medical History: Please check any problem you have had and explain. If you have not had any problems, check "no".

General (constitutional)

Yes	No	
____	____	weight loss_____
____	____	lack of energy _____
____	____	trouble sleeping _____
____	____	problems with anesthesia _____

Eyes

Yes	No	
____	____	vision loss _____
____	____	any change in vision _____
____	____	eye pain _____
____	____	dry eye _____
____	____	other _____

Ears, Nose, Mouth, Throat

Yes	No	
____	____	hearing loss _____
____	____	sinus problems _____
____	____	infections _____
____	____	other _____

Lungs (respiratory)

Yes	No	
____	____	asthma _____
____	____	bronchitis _____
____	____	shortness of breath _____
____	____	tuberculosis (TB) _____
____	____	other _____

Stomach & Intestines (gastrointestinal)

Yes	No	
____	____	ulcers _____
____	____	diverticulitis _____
____	____	constipation _____
____	____	hepatitis _____
____	____	other _____

Kidneys, Bladder, Prostate, (genitourinary)

Yes	No	
____	____	kidney infections _____
____	____	urinary infections _____
____	____	cancer _____
____	____	on dialysis (list days)_____
____	____	other _____

Heart & Blood Vessels

Yes No

____ ____ heart attack _____
____ ____ high blood pressure _____
how long? _____
last check? _____
____ ____ heart murmur _____
____ ____ irregular heart beat _____
____ ____ mitral valve prolapsed _____
____ ____ chest pain _____
____ ____ circulation problems _____
____ ____ other _____

Nervous system & Brain

Yes No

____ ____ seizure _____
____ ____ stroke _____
____ ____ paralysis/weakness _____
____ ____ numbness _____
____ ____ other _____

Mental Illness (psychiatric)

Yes No

____ ____ depression _____
____ ____ chemical imbalance _____
____ ____ mania, bipolar _____
____ ____ schizophrenia _____
____ ____ other _____

Endocrine System

Yes No

____ ____ diabetes _____
____ ____ thyroid condition _____
____ ____ other _____

Bones, Respiratory, Muscles (Musculoskeletal)

Yes No

____ ____ osteoporosis _____
____ ____ arthritis _____
____ ____ muscle pain _____
____ ____ other _____

Skin/Breast (Integumentary)

Yes No

____ ____ Keloid scarring _____
____ ____ rashes, sensitivities _____
____ ____ skin cancer _____
____ ____ breast cancer _____
____ ____ other _____

Blood (hematoioiogic/lymphatic)

Yes No

____ ____ anemia (low blood count) _____
____ ____ excessive bleeding _____
____ ____ clotting problems _____
____ ____ other _____

Allergic/Immunologic

Yes No

____ _____ lupus _____
____ _____ arthritis _____
____ _____ HIV _____
____ _____ other _____

Social History

What is your occupation? _____ Are you still working? _____
Do you still smoke cigarettes? _____ If "yes", how may per day? _____ For how many years? _____
Do you drink alcohol? _____ If "yes", how much? _____For how many years? _____
Do you exercise? _____ If "yes", what kind? _____How often? _____

Have you ever lived outside of Hawaii? _____ If "yes", where? _____ How long? _____
Past and present drug use (legal and illegal) is important for drug and anesthetic interactions. Please indicated if we need to be aware of any drug use _____ yes _____ no
Have you had a blood transfusion since 1977? _____

Family Medical History: Has any member of your family (father, mother, father's parents, mother's parents, brothers, sisters) had any of the following medical problems? Please check "yes" or "no" and list which member of your family (write down "mother" of "brother", etc.) had the problem in the space provided.

Yes No

____ ____ diabetes _____
____ ____ thyroid disease _____
____ ____ stroke _____
____ ____ anemia _____
____ ____ hepatitis _____
____ ____ cancer _____
Type _____
____ ____ glaucoma _____

Yes No

____ ____ tuberculosis _____
____ ____ heart disease _____
____ ____ high blood pressure _____
____ ____ kidney disease _____
____ ____ bleeding disorder _____
____ ____ problems with anesthesia _____
____ ____ I do not know my family history _____

Is there anything not mentioned on this form you would like your doctor to know?

_____

Signature: _____ Date: _____