Eye Surgery Associates Medical History Form

Name:	**Birth Date:**	**Medical Dr.**
Pharmacy:	**Height:** **Weight:**	**Other Dr.**

Please check all that apply if you have had or currently have any of the following:

□ Acid Reflux/ stomach problem □ AIDS/HIV □ Allergies □ Anesthesia problem □ Aneurysm □ Anxiety/ Bipolar/ Depression □ Arthritis/ Gout □ Asthma/ Emphysema/COPD □ Autism □ Bell's Palsy □ Blood/Lymph disorder □ Blood clot/transfusion □ Cancer □ chemo □ radiation □ Carotid disease □ Cataract □ Cerebral palsy □ Crohn's disease	□ Deafness □ Dementia/ Alzheimer's □ Diabetes - since _____ □ Dialysis □ Diverticulitis □ Epilepsy □ Erectile dysfunction/impotence □ Glaucoma □ Graves' disease □ Headache □ Head trauma □ Hearing loss □ Heart disease □ Atrial fibrillation □ Arrhythmia □ Blockage □ Congestive heart failure □ Heart attack	□ Hepatitis □ Hernia □ Herpes virus □ High blood pressure □ High cholesterol □ Inner ear disease □ Kidney disease □ Liver disease □ Lupus □ Lyme disease □ Macular degeneration □ Memory loss □ MRSA □ Multiple sclerosis □ Myasthenia gravis □ Organ transplant □ Oxygen dependent	□ Parkinson's □ Prostate disorder □ Pseudotumor cerebri □ Restless leg syndrome □ Rosacea □ Sarcoidosis □ Shingles □ Sinus disease □ Sjogrens □ Sleep apnea □ Stroke/ TIA □ TB □ Temporal arteritis □ Thyroid disorder □ Vertigo/ dizziness □ Other: _____ _____ _____ _____

Please check all that apply if you have had any of the following surgeries:

□ Amputation □ Aneurysm □ Appendectomy □ Back □ Bladder □ Bone □ Brain □ Breast □ Carotid	□ Colon □ Cosmetic □ C-section □ Dental □ Ear □ Exploratory □ Eye □ Gallbladder □ Gastric bypass	□ Heart □ Ablation □ Angioplasty □ Bypass □ Cath □ Defibrillator □ Pacemaker □ Stent	□ Hernia □ Hysterectomy □ Joint replacement □ Kidney □ Lung □ Nose □ Prostate	□ Surgery due to cancer □ Thyroid □ Tonsillectomy □ Vascular □ Vasectomy □ Other: _____ _____

Please check all that apply if you have had any of the following allergies:

□ Dye for testing □ Iodine	□ Latex □ Pain medicine	□ Penicillin □ Statin drugs	□ Sulfa □ Other:

Please check all that apply if your parents, siblings or children have had any of the following:

□ Cataract □ Cancer □ Diabetes	□ Glaucoma □ Heart disease □ High blood pressure	□ Macular degeneration □ Stroke	□ Other: _____ _____

1. **Do you smoke? Y N** **2. Do you drink alcohol? Y N** **3. Have you had a pneumonia vaccine? Y N**

Please bring a list of your medications with you to your appointment, including any over the counter or supplements you may take. Include the milligram and how often you take it.

If you wear glasses, please bring them with you to your appointment.