## **Eye Surgery Associates Medical History Form**

Name:					Birth Date:				Medical Dr.		
Pharmacy:				Heigh	Height: Weight:			Other Dr.			
lease check	c all t	that apply if y	ou l	have had	d or cur	rently h	ave any	y of t	the follow	ing:	
□ Acid Reflux/ stomach problem				□ Deafness			□ Hepatitis			□ Parkinson's	
□ AIDS/HIV				□ Dementia/ Alzheimer's			□ Hernia			□ Prostate disorder	
□ Allergies				□ Diabetes - since			□ Herpes virus			□ Pseudotumor cerebri	
□ Anesthesia problem			ialysis			□ High	blood	d	□ Restless leg syndrome		
□ Aneurysm				□ Diverticulitis			pressure			□ Rosacea	
□ Anxiety/ Bipolar/ Depression				□ Epilepsy			□ High cholesterol			□ Sarcoidosis	
□ Arthritis/ Gout				□ Erectile			□ Inner ear disease			□ Shingles	
□ Asthma/ Emphysema/COPD				dysfunction/impotence			□ Kidney disease			□ Sinus disease	
□ Autism				□ Glaucoma			□ Liver disease		ase	□ Sjogrens	
□ Bell's Palsy				□ Graves' disease			□ Lupus			□ Sleep apnea	
□ Blood/Lymph disorder				□ Headache			□ Lyme disease		ease	□ Stroke/ TIA	
□ Blood clot/transfusion				□ Head trauma			□ Macular			□ TB	
□ Cancer				□ Hearing loss			degeneration			□ Temporal arteritis	
□ chemo				□ Heart disease			□ Memory loss		oss	□ Thyroid disorder	
□ radiation				□ Atrial fibrillation			□ MRSA			□ Vertigo/ dizziness	
□ Carotid disease				□ Arrhythmia			□ Multiple sclerosis			□ Other:	
□ Cataract			□ Blockage						ia gravis		
		□ Cerebral palsy			□ Congestive heart failure			□ Organ transplant			
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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.