EYE PLASTIC & FACIAL COSMETIC SURGERY, P.C.

2757 Leonard NE • Suite 300 • Grand Rapids, MI 49525 • (616) 942-6687 • fax (616) 942-9797

MEDICAL HISTORY

PLEASE PRINT

Patient's Name _____

Primary Care Physician's Name _____

When was your last visit to your Primary Care Physician? _____

What is your estimate of your general health? ☐ POOR ☐ FAIR ☐ GOOD

What is the chief complaint or reason for your visit with our office? _____

HAVE YOU EVER HAD THE FOLLOWING *(Please Check)*

Allergic Reaction to:			Liver Disease	☐ YES	☐ NO
Penicillin or Other Antibiotic	☐ YES	☐ NO	Hepatitis or Jaundice	☐ YES	☐ NO
Aspirin or Ibuprofen	☐ YES	☐ NO	Kidney Disease	☐ YES	☐ NO
Any Eye Drops: _____	☐ YES	☐ NO	Thyroid or Parathyroid Problems	☐ YES	☐ NO
Anesthetics or Sedatives	☐ YES	☐ NO	Graves Disease	☐ YES	☐ NO
Latex	☐ YES	☐ NO	Ulcers	☐ YES	☐ NO
Other Medications: _____	☐ YES	☐ NO	Digestive Disorders / Acid Reflux	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO	Diabetes (Insulin / Diet Controlled)	☐ YES	☐ NO
Antibiotics before Medical or Dental Procedure	☐ YES	☐ NO	Arthritis	☐ YES	☐ NO
Artificial Heart Valve	☐ YES	☐ NO	Artificial Joints (Hip, Knee, etc.)	☐ YES	☐ NO
Heart (Surgery, Disease, Attack, Arrhythmia)	☐ YES	☐ NO	Head or Neck Injuries	☐ YES	☐ NO
Rheumatic Fever	☐ YES	☐ NO	Epilepsy, Convulsions (Seizures)	☐ YES	☐ NO
Heart Pacemaker	☐ YES	☐ NO	Viral Infections	☐ YES	☐ NO
High Blood Pressure / Usual BP: _____	☐ YES	☐ NO	Cold Sores / Fever Blisters	☐ YES	☐ NO
Low Blood Pressure	☐ YES	☐ NO	AIDS or HIV Infection	☐ YES	☐ NO
Stroke	☐ YES	☐ NO	Sexually Transmitted Disease	☐ YES	☐ NO
Anemia or Other Blood Disorder	☐ YES	☐ NO	Cortisone Medication	☐ YES	☐ NO
Prolonged Bleeding due to a Cut	☐ YES	☐ NO	Cancer – Type: _____	☐ YES	☐ NO
Lung or Breathing Problems	☐ YES	☐ NO	Chemotherapy	☐ YES	☐ NO
Tuberculosis	☐ YES	☐ NO	Radiation Therapy	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Emotional Problems	☐ YES	☐ NO
Hives or Skin Rash	☐ YES	☐ NO	Psychiatric Treatment	☐ YES	☐ NO
Persistent Cough	☐ YES	☐ NO	Alcohol / Drug Dependency	☐ YES	☐ NO
Sinus Problems	☐ YES	☐ NO	Hearing Problems	☐ YES	☐ NO
Multiple Sclerosis	☐ YES	☐ NO	Appetite Changes	☐ YES	☐ NO
Sleep Apnea	☐ YES	☐ NO	Unexplained Weight Loss or Gain	☐ YES	☐ NO

ARE YOU: *(Please Check)*

Presently being Treated for any Illness	☐ YES	☐ NO	Considered a Touchy Person	☐ YES	☐ NO
Aware of any Change in your Health	☐ YES	☐ NO	Easily Upset or Irritated	☐ YES	☐ NO
Often Exhausted or Fatigued	☐ YES	☐ NO	Often Unhappy or Depressed	☐ YES	☐ NO
Having Difficulty Sleeping	☐ YES	☐ NO	Female – Taking Birth Control Pills	☐ YES	☐ NO
Having Night Sweats	☐ YES	☐ NO	Female – Pregnant	☐ YES	☐ NO
A Smoker – Packs per Day / Week: _____	☐ YES	☐ NO	Female – Nursing	☐ YES	☐ NO

(continued on other side)

MEDICAL HISTORY *(cont.)*

DO YOU HAVE A HISTORY OF: *(Please Check)*

Eyelid Disease or Surgery ☐ RIGHT EYE ☐ LEFT EYE *Complications:* _____	Cornea Disease or Surgery ☐ RIGHT EYE ☐ LEFT EYE *Complications:* _____
Tear Duct Surgery ☐ RIGHT EYE ☐ LEFT EYE *Complications:* _____	Retina / Macular Disease or Surgery ☐ RIGHT EYE ☐ LEFT EYE *Complications:* _____
Dry Eyes ☐ RIGHT EYE ☐ LEFT EYE *Complications:* _____	Eye Infection or Injury ☐ RIGHT EYE ☐ LEFT EYE *Complications:* _____
Cataracts or Cataract Surgery ☐ RIGHT EYE ☐ LEFT EYE *Complications:* _____	Family Eye Disease ☐ RIGHT EYE ☐ LEFT EYE *Complications:* _____
Glaucoma or Glaucoma Surgery ☐ RIGHT EYE ☐ LEFT EYE *Complications:* _____	Other: _____ ☐ RIGHT EYE ☐ LEFT EYE _____

PLEASE COMPLETE:

Please list any previous surgeries or hospitalizations: _____

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your treatment with us: _____

_____

_____

List any medications, eye medications, herbal supplements, and/or vitamins taken within the last 14 days: _____

_____

_____

Do you have any problems with your skin or complexion? _____

_____

_____

Would you like a consultation with our skin care specialist? _____

_____

_____

AUTHORIZATION:

Please advise us in the future of any change in your medical history or any medications you may be taking.

I understand the above information is necessary to provide me with care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

SIGNATURE: _____ DATE: _____

FOR DOCTOR'S USE ONLY

Doctor's Remarks: _____

_____

_____