Oculofacial Plastic & Orbital Surgery

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Gender □ Male □ Female	DOB

Mailing Address	City	State	Zip

Primary Phone □ Cell □ Other	Secondary Phone □ Cell □ Other	Email

Social Security #	Race	Ethnicity	Language	How do you want to receive appt reminders? □ Phone □ Text □ Email □ None

Patient's Employer	Employer Phone	Occupation

Marital Status □ Single □ Married □ Divorced □ Widowed	Spouse's First & Last Name	Spouse's Phone

Pharmacy Name & Address	Pharmacy Phone

PARENT/GUARDIAN INFORMATION (FILL OUT IF PATIENT IS UNDER 18 YEARS OF AGE)

□ Mother □ Father □ Other _____	First & Last Name	Phone

□ Mother □ Father □ Other _____	First & Last Name	Phone

EMERGENCY CONTACT

First & Last Name	Phone	Relationship

PROVIDERS

Referring Provider Name	Phone	Primary Care Dr Name	Phone

Eye Doctor Name	Phone	Other Specialist Name	Phone

INSURANCE INFORMATION

Primary Insurance: Carrier Name	ID #	Group #

Policy Holder Name	Policy Holder DOB	Relationship to Patient

Secondary Insurance: Carrier Name	ID #	Group #

Policy Holder Name	Policy Holder DOB	Relationship to Patient

RESPONSIBLE PARTY INFORMATION

□ Self □ Other _____ □ Mother □ Father	First & Last Name (If Not Self)	Phone

Address	City	State	Zip

Oculofacial Plastic & Orbital Surgery

Medical History

Name: _____ **Birthdate:** _____ **Date:** _____

Referring Physician: _____ **Why referred?** _____

Primary Doctor: _____ **Cardiologist:** _____

Eye Symptoms (check all that apply)

- ☐ Eyelid Growth
- ☐ Loss of Vision
- ☐ Sudden Change of Vision
- ☐ Blurred Vision
- ☐ Distorted Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Itching
- ☐ Burning
- ☐ Tearing
- ☐ Redness
- ☐ Discharge
- ☐ Chronic Infections
- ☐ Eye Pain
- ☐ Droopy Lids
- ☐ Flashes of Light
- ☐ Floaters/Spots
- ☐ Lazy/Crossed Eyes
- ☐ Halos Around Lights
- ☐ Eye Injuries

Other: _____

Review of Symptoms - Do you have or are you being treated for any of the following conditions?

Constitutional
- ☐ Fever
- ☐ Weight Loss

Ears,Nose and Throat
- ☐ Recent Cold
- ☐ Hearing Changes
- ☐ Sinus Problems

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Cardiovascular Event
- ☐ Pacemaker/Defibrillator
- ☐ High Blood Pressure
  - ☐ Controlled
  - ☐ Uncontrolled
- ☐ High Cholesterol

Cancer - Type
- ☐ _____

Respiratory
- ☐ Lung Disorders
- ☐ Breathing Problems
- ☐ Chronic Cough
- ☐ Sleep Apnea

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting

Neurological
- ☐ Stroke
- ☐ Head Injury
- ☐ Headaches
- ☐ Paralysis
- ☐ Seizures
- ☐ Memory Loss

Genitourary
- ☐ Bladder/Prostate Problems
- ☐ Kidney Problems

Females
- ☐ Pregnant
- ☐ Nursing

Skin
- ☐ Skin Disorders
- ☐ Rashes
- ☐ Changes in Mole(s)
- ☐ Lumps in Breasts

Musculoskeletal
- ☐ Arthritis
- ☐ Joint Pain
- ☐ Muscle Pain

Endocrine
- ☐ Diabetes
  - ☐ Stable
  - ☐ Unstable
- ☐ Thyroid Disorders

Lymphatics
- ☐ Swollen Lymph Nodes
- ☐ Swelling
- ☐ Reoccurring Infections

Allergy/Immunology
- ☐ Environmental Allergies
- ☐ Seasonal Allergies
- ☐ Immune Disorders

Psychiatric
- ☐ Anxiety
- ☐ Depression

List medications you are currently taking (including eye medications, over the counter and supplements/vitamins)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Medical History Page 2

Name: _____ Birthdate: _____

Medical History

Latex Allergy? ☐ **Yes** ☐ **No**

List all medication allergies: _____

List all major illnesses. Give approximate year of onset.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

List all surgeries, including eye surgeries and dates of each:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Do you have any metal in your body? ☐ **Yes** ☐ **No**

If yes, describe: _____

Have you or anyone in your family had significant problems with anesthesia? ☐ **Yes** ☐ **No**

If yes, describe: _____

Social History

Height: _____ **Weight:** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Occupation: _____

Smoking? ☐ **Never Smoked** ☐ **Ex-Smoker (Quit Date: _____)** ☐ **Smoker (Packs/Day _____)**

Alcohol: ☐ **None** ☐ **Occasional** ☐ **1-2 Drinks/Day** ☐ **3+ Drinks/Day**

Do you use street drugs? ☐ **Yes** ☐ **No** **If yes, what type?** _____

Do you drive? ☐ **Yes** ☐ **No** **Visual difficulty with driving?** ☐ **Yes** ☐ **No**

Do you wear glasses or contacts? ☐ **Yes** ☐ **No** **If yes, how long?** _____

Family History - Has anyone in your immediate family had the following?

☐ Blindness ☐ Glaucoma ☐ Retinal Detachment ☐ Diabetes

☐ Crossed/Lazy Eye ☐ Macular Degeneration ☐ Cancer ☐ Hypertension

Other: _____

History Reviewed by - Physician's Signature