Williams Eye Institute

Patient Health History (please print)

Referring Doctor: _____ **Primary Care Physician:** _____

Specialist Doctor: _____ **Date of Last Exam with Medical Physician:** _____

Pharmacy #1 Name/Address/Phone: _____

Pharmacy #2 Name/Address/Phone: _____

Have you been hospitalized within the past three months? (circle) **YES** **NO**

If yes, please explain: _____

Influenza Vaccine Received (circle) **YES** **NO** Pneumonia Vaccine Received (circle) **YES** **NO**

History of Medical Problems

	Y	N	How long?		Y	N	How Long?
Diabetes				Cancer			
High Blood Pressure				Hepatitis			
Heart Disease				Kidney Dialysis			
Respiratory Problems				Rheumatoid Problems			
Neurological Problems				Multiple Sclerosis			
Depression/Anxiety				Pacemaker			
Thyroid Problems				Defibrillator			
Other							

Current Medications	Dose	Frequency

Have you or an immediate family member ever been told you have the following eye problems?

(check all that apply and circle appropriate person)

☐	**Glaucoma**	**Self**	**Family Member**	☐	**Retinal Detachment**	**Self**	**Family Member**
☐	**Cataracts**	**Self**	**Family Member**	☐	**Macular Degeneration**	**Self**	**Family Member**
☐	**Other:**					**Self**	**Family Member**

Past Major Surgeries (type & year): _____

_____

Allergies to Medications: _____

Other Allergies: _____ **Latex Allergy? (circle)** **YES** **NO**

Tobacco Use? **(circle)** **NO** **YES** _____ packs per day Have you smoked in the past? (circle) **YES** **NO**

Alcohol Use? **(circle)** **Never** **Occasionally** **Daily** Do you live alone? **(circle)** **YES** **NO**

Are you currently or have you lived in a temporary rehabilitation center within the past year? **(circle)** **YES** **NO**

Patient Signature: _____ **Date:** _____

Williams Eye Institute

Expanded Health History for Surgical Consultations (PLEASE FILL OUT IF YOU ARE HERE FOR A CATARACT OR EYELID SURGERY EVALUATION IN ADDITION TO PAGE 1)

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____
Name of Cardiologist: _____ **Last Seen?** _____
Have you been hospitalized in the past 3 months? (circle) **YES NO**
If yes, please explain?

_____

Have you had any cardiac testing within the past 3 months? (circle) **YES NO**
If yes, please explain? _____

_____

Do you use Oxygen at home? (circle) **YES NO**

Please select the following medical conditions you have been diagnosed with:

Lung

- ☐ COPD (Emphysema/Bronchitis)
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Other, please explain: _____

Vascular

- ☐ Hypertension (High Blood Pressure)
- ☐ Heart Attack, if so, when? _____
- ☐ Pacemaker, if so, when was it last checked? _____
- ☐ Defibrillator, if so, when was it last checked? _____
- ☐ Irregular Heartbeat, if so, what type? _____
- ☐ Chest Pain, if so when did you last have chest pain? _____ How often? _____
- ☐ Heart Disease (Coronary Artery Disease, Valvular Heart Disease, Congestive Heart Failure)
  - If any, what heart procedures/surgeries have you had? _____
  - When? _____

Systemic

- ☐ Stroke/Parkinson's/Tremors, if so, when? _____
- ☐ Diabetes or Thyroid problems
- ☐ Hepatitis A, B, C/ Jaundice, if so, when? _____
- ☐ Rheumatoid conditions/Arthritis/Lupus, if so when diagnosed? _____
- ☐ Kidney Dialysis, if so, what days? _____
- ☐ Bladder disease
- ☐ Stomach/Bowel related diseases
- ☐ Cancer, if so, what type? _____ When diagnosed? _____
  - Are you currently undergoing Chemo or Radiation? (circle) **YES NO**
  - Who is your Oncologist? _____