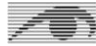
 **Williams Eye Institute**

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?
Diabetes			
High Blood Pressure			
Heart Disease			
Respiratory Problems			
Neurological Problems			
Depression/Anxiety			
Thyroid Problems			
Other			

	Y	N	How Long?
Cancer			
Hepatitis			
Kidney Dialysis			
Rheumatoid Problems			
Multiple Sclerosis			
HIV/AIDS			
Pacemaker			
Defibrillator			

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

Past Major Surgeries (type & year): ____

____

Allergies to Medications: ____

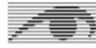
Other Allergies: ________________________________ **Latex Allergy? (circle)** **YES** **NO**

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**

Have you ever had a MRSA or Staph infection? (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? ____