Williams Eye Institute

Patient Health History (please print):

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

Date of Last Exam with Medical Physician: _____

Pharmacy #1 Name/Address/Phone: _____

Pharmacy #2 Name/Address/Phone: _____

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

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**

Medical History (Check and/or circle all that apply):

_____COPD (Emphysema/Bronchitis)	_____ High Blood Pressure	____ Stroke/Seizures/Parkinson's/Tremors
_____ Asthma	_____ Heart Attack	____ Diabetes/Thyroid/Lupus
_____ Chronic Cough	_____ Pacemaker/Defibrillator	____ Hepatitis A, B, C/Jaundice
_____ Shortness of breath	_____ Irregular Heartbeat	____ Arthritis
_____ Sleep Apnea	_____ Chest Pain	____ Multiple Sclerosis
_____ Depression/Anxiety	_____ Heart Disease (CAD/VHD/CHF)	____ Kidney/Bladder Problems
_____ Cancer / Type:_____	_____ HIV/AIDS	____ Stomach/Bowel Problems

_____ Other (Please explain):_____

Past Major Surgeries (type & year): _____

_____

Allergies: _____

Latex Allergy: YES NO

Current Medications: **Please list below or attach medication list.*	**Dose**	**Frequency**	**Route**

Tobacco Use? **Never** **____ packs per day** **Quit _____ years ago**

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

Do you live in a Skilled Nursing Facility? **YES NO**

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

Patient Signature: _____ **Date:** _____

Williams Eye Institute

EXPANDED HEALTH HISTORY FOR SURGICAL CONSULTATIONS

Do you have a history of MRSA / Staph Infection? Yes / No

If yes, when was treatment completed?_____

Have you been hospitalized overnight or longer in the last 3 months? Yes / No

If yes, what was the reason?_____

Have you fallen recently? Yes / No If yes, what was the reason?_____

Do you use a walking aid? Yes / No If yes, what type? Cane / Walker / Wheelchair / Other_____

Have you had any cardiac surgery in the past? Yes / No

If yes, what was the surgery? CABG / TAVR / Open Heart Surgery / Open Vascular Surgery / Ruptured AAA Repair / Angiogram / Stent placement / Cardioversion / Ablation / Other

Dates of procedure(s):_____

If you had an ablation, what was the reason?_____

Do you have an implantable device? Pacemaker / Defibrillator / Watchman / Loop Recorder? Yes / No

If yes, when was it implanted?_____

Date of last interrogation of Pacemaker and/or Defibrillator:_____

Have you had cardiac testing or procedures in the last 3 months? Yes / No

If yes, what testing was done? EKG / Echo / Stress test / Other_____

What was the reason?_____ What were the results?_____

Has your doctor ordered additional cardiac testing to be done? Yes / No

If so, what? _____

Have you ever had a stroke or TIA? Yes / No

If yes, when?_____

Have you even been diagnosed with an aneurysm? Yes / No If yes, where?_____

Have you had surgery to repair the aneurysm? Yes / No

Date and type of surgery:_____

Have you ever had an organ transplant? Yes / No

If yes, what organ?_____ Date of transplant:_____

Do you wear oxygen at home? Yes / No

If yes, how many liters?_____ Continuous / As needed

Cardiologist Name and Phone Number:_____

Pulmonologist Name and Phone Number:_____

Neurologist Name and Phone Number:_____

Other:_____