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):

_____ Heart Failure	_____ Home O2	____ Anemia/bleeding disorder
_____ Coronary artery disease	_____ Sleep Apnea (uses CPAP/BiPAP)	____ Kidney/bladder problems
_____ Heart attack – date _____	_____ Seizure disorder	____ Dialysis
_____ Heart Disease (CAD, CHF, arrhythmia)	_____ Stroke/TIA	____ Sickle cell disease
_____ High blood pressure	_____ Neuromuscular disease (Parkinsons/MS/Myasthenia/ALS)	
_____ Heart valve disease	_____ Dementia/memory impairment	____ Infectious disease/HIV/AIDS/MRSA
_____ Vascular disease (carotid/femoral)	_____ Tremors	____ Cancer/type: _____
_____ Pacemaker/Defibrillator	_____ Diabetes	____ Arthritis
_____ Blood clots (DVT/PE)	_____ Thyroid disorder	____ Chronic back or neck pain
_____ Shortness of breath	_____ Tracheotomy or stoma	____ Depression/anxiety
_____ COPD (emphysema/bronchitis)	_____ Gerd/Acid reflux/ulcera	____Bipolar/Schizophrenia
_____ Asthma	_____ Hepatitis/Liver disease	____ PTSD/claustrophobia
_____ Chronic cough	_____ Other: _____	

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:** _____

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EXTENDED HEALTH HISTORY FOR SURGICAL CONSULTATIONS

Do you take GLP-1 (Ozempic, Wegovy, etc) Yes / No

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 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:_____