Todays Date : ______________________________

Demographics

Patient Name:_________________________________ DOB: ____________________

Address: ____________________________________ Gender: __________________

Cell # ______________________________________

Home # _____________________________________

Email:______________________________________

Primary Care

Primary Care Physician: ______________________ Phone #_________________________

______________________ Fax: _________________________

Pharmacy:

Pharmacy: ___________________________________ Phone #_________________________

Location: ____________________________

____

Referral

Referring Doctor: ______________________________ Phone #_________________________

____

Visit

Nature of Visit? ____

____

Emergency Contact

Name: _____________________________________ Relationship: ______________________

Phone Number: ______________________________

May we release your health & financial information to your emergency contact?

Yes No

Do you have a health care proxy in the event you are unable to make your own medical decisions?

Name: _____________________________________ Relationship: ______________________

Phone Number: ___________________________

I do not have a health care proxy.

Medical History

Height: ________________________________ Weight: ______________________________

Allergies

Do you have any allergies to any medications:

Yes:

No

Have you ever had any allergic reaction to anethesia? Yes No

Severity: ____

Reaction: ____

Social History

Do you smoke?	Never	Former	Current
Do you drink alcohol?	No	Yes	
Do you drink 5 or more drinks per day more than 5 times a year?	No	Yes	

Medical History

		Description:	
☐	Arthritis		
☐	COPD		
☐	Depression		
☐	End Stage Kidney Disease		
☐	History of Hypertension		
☐	HIV		
☐	High Cholestrol		
☐	Leukemia		
☐	Diabetes:	Type 1	Type 2
☐	Malignant Lymphoma		
☐	Cancer of Colon		
☐	Asthma		
☐	Atrial Fibrillation		
☐	Autoimmune Disease		
☐	Bleeding Disorder		
☐	Deep Venous Thrombosis		
☐	Thyroid Disorder		
☐	Epilepsy		
☐	Hearing Loss		
☐	Disorder of Heart		
☐	Pulmonary Embolism		
☐	Rheumatoid Arthritis		
☐	Other:		
☐			
☐			
☐			
☐			

Surgical History

		Descritpion:
☐	History of Colectomy	
☐	Excision of Basal Cell Carcinoma	
☐	Excision of Melanoma	
☐	Repair of Heart	
☐	Other	
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		
☐		

Ocular History

Macular Degeneration	L	R
Retinal Tear	L	R
Current Contact Lens Wear	L	R
Dry Eyes	L	R
Glaucoma	L	R
History of Cataract	L	R
Strabismus	L	R
	L	R

Other : ____

Medications

Are you on Pain Management?	Y	N
Are you taking Aspirin?	Y	N
Are you taking Medications?	Y	N

Medication Name	Dosage (mg/ml)	Frequency