PATIENT HEALTH HISTORY SCOTTSDALE EYE SURGERY CENTER, P.C.

NAME: _____ DATE: _____

AGE: _____ WEIGHT: _____ HEIGHT: _____ CONTACTS: ❑ RIGHT ❑ LEFT

DENTURES: ❑ UPPER ❑ LOWER HEARING AIDS: ❑ RIGHT ❑ LEFT DO YOU HAVE PAIN YES / NO

Name of person taking you home: _____

RELATIONSHIP: _____ PHONE #: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____ PHONE #: _____

DOCTORS

Please list all the doctors involved in your care

NAME	REASON (ex. heart, diabetes)	PHONE #

MEDICATION ALLERGIES ❑ NO KNOWN ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION

Are you sensitive to any of the following?
❑ Iodine ❑ Topical ❑ Injected IV
❑ Tape ❑ Paper ❑ Cloth
❑ Latex
Reaction: _____

ANESTHESIA REACTIONS:

Have you had any complication related to anesthesia? ❑ Yes ❑ No ❑ General ❑ Local

Describe reaction _____

Malignant Hyperthermia ❑ Yes ❑ No

Family Member with Complications Related to Anesthesia ❑ Yes ❑ No

Describe reaction _____

MEDICAL HISTORY — **PLEASE CHECK ALL THAT APPLY**

HEART AND VASCULAR
- ❑ Heart Attack(s) (Dates): _____
- ❑ Angina/Chest Pain
- ❑ Murmur
- ❑ Abnormal Rhythm
- ❑ High Blood Pressure
- ❑ Heart Failure
- ❑ Pacemaker
- ❑ Mitral Valve Prolapse
- ❑ High Cholesterol
- ❑ Other: _____

LUNGS
- ❑ Asthma/Wheezing
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Chronic Cough
- ❑ TB (or Family History)
- ❑ Shortness of Breath
- ❑ Recent Cough/Cold
- ❑ Sleep Apnea
- ❑ Other: _____

GENITAL/ URINARY
- ❑ Kidney or Renal
- ❑ Dialysis Schedule: _____
- ❑ Other: _____

GASTRO-INTESTINAL
- ❑ Liver Disease
- ❑ Jaundice
- ❑ Hiatal Hernia/Reflux
- ❑ Other: _____

BLOOD AND COAGULATION
- ❑ Aids/HIV
- ❑ Hepatitis Type: _____
- ❑ Anemia
- ❑ Bruising
- ❑ Other: _____

NERVOUS SYSTEM
- ❑ Stroke
- ❑ Seizures/Epilepsy
- ❑ Head/Neck Injury
- ❑ Other: _____

ENDOCRINE
- ❑ Diabetes
- ❑ Insulin
- ❑ Thyroid Disease
- ❑ Other: _____

MUSCULO-SKELETAL SYSTEM
- ❑ Chronic Back or Neck Trouble
- ❑ Arthritis
- ❑ Multiple Sclerosis
- ❑ Other: _____

OTHER
- ❑ Glaucoma ❑ Rt ❑ Lt
- ❑ Hearing Loss ❑ Rt ❑ Lt
- ❑ Breast Feeding
- ❑ Cancer Type: _____
- ❑ Pregnant
- ❑ Other: _____

DO NOT WRITE IN THIS SPACE

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

PLEASE COMPLETE OTHER SIDE

SCOTTSDALE EYE SURGERY CENTER, P.C.

SIGNATURE OF PARENT OR GUARDIAN DATE

MEDICATIONS ❑ ***I DO NOT TAKE ANY MEDICATIONS***

Please list all the medications you take which require a doctor's prescription.

NAME OF MEDICINE	DOSE OF MEDICINE Mg, units, cc's	HOW OFTEN TAKEN

PLEASE CHECK ANY OVER-THE-COUNTER MEDICINES YOU ARE PRESENTLY TAKING:

- ❑ NONE
- ❑ Antacids
- ❑ Aspirin Containing Products
- ❑ Cold/Cough remedies
- ❑ Diarrhea Preparations
- ❑ Eye Drops
- ❑ Herbal Remedies
- ❑ Laxatives
- ❑ Pain Medicines
- ❑ Sleeping Medicine
- ❑ Vitamin/Supplements
- ❑ Recreational Drugs
- ❑ Weight Loss Medications
- ❑ Other:_____

Have you taken cortisone or other steroid medicine in the last year? ❑ Yes ❑ No

If yes, name of drug _____ For What?_____

Have you taken any anticoagulant (blood thinner or aspirin) medicine in the last 3 months? ❑ Yes ❑ No

If yes, name of drug _____ For What?_____ Last Dose:_____

SURGICAL HISTORY

LIST PREVIOUS SURGERIES/INJURIES/HOSPITALIZATIONS OR PROCEDURES (INCLUDE EYE SURGERIES) ❑ **NONE**

DATE	PROCEDURES

OTHER

Yes No

❑ ❑ Do you use tobacco?
❑ Cigarettes_____ packs/day ❑ Cigars ❑ Pipe ❑ Chew ❑ Quit when?_____ Years of use?_____

❑ ❑ Do you use alcohol? How much?_____ Last drink _____

❑ ❑ Prosthetic Devices: ❑ Joint Replacements ❑ Lens Implants ❑ Right ❑ Left ❑ Other _____

PLEASE COMPLETE OTHER SIDE