EYE PLASTIC & FACIAL COSMETIC SURGERY, P.C.
2757 Leonard NE • Suite 300 • Grand Rapids, MI 49525 • (616) 942-6687 • fax (616) 942-9797

MEDICAL HISTORY

PLEASE PRINT

Patient's Name ______________________________

Primary Care Physician's Name ______________________________ Date of your last visit: ______________

What is your estimate of your general health? ☐ POOR ☐ FAIR ☐ GOOD

What is the chief complaint or reason for your visit with our office? ______________________________

HAVE YOU EVER HAD THE FOLLOWING (Please Check)

Allergies: List all Medication Allergies & Reactions

Condition	YES	NO
Latex Allergy	☐ YES	☐ NO
Reaction to Anesthesia	☐ YES	☐ NO
Heart Stents: Date: ________	☐ YES	☐ NO
Heart Surgery: Date: ________	☐ YES	☐ NO
Antibiotics before Medical or Dental Procedure	☐ YES	☐ NO
Artificial Heart Valve	☐ YES	☐ NO
Heart (Disease / Attack / Arrhythmia / Murmur)	☐ YES	☐ NO
Rheumatic Fever	☐ YES	☐ NO
Heart Pacemaker	☐ YES	☐ NO
High Blood Pressure / Usual BP: ________	☐ YES	☐ NO
Low Blood Pressure	☐ YES	☐ NO
Stroke / TIAS	☐ YES	☐ NO
Anemia or Other Blood Disorder	☐ YES	☐ NO
Prolonged Bleeding due to a Cut	☐ YES	☐ NO
Lung or Breathing Problems	☐ YES	☐ NO
Tuberculosis	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Hives or Skin Rash	☐ YES	☐ NO
Persistent Cough	☐ YES	☐ NO
Sinus Problems	☐ YES	☐ NO
Multiple Sclerosis	☐ YES	☐ NO
Sleep Apnea	☐ YES	☐ NO

Condition	YES	NO
Liver Disease	☐ YES	☐ NO
Hepatitis or Jaundice	☐ YES	☐ NO
Kidney Disease	☐ YES	☐ NO
Thyroid or Parathyroid Problems – RAI ☐ Y / N	☐ YES	☐ NO
Graves Disease	☐ YES	☐ NO
Ulcers	☐ YES	☐ NO
Digestive Disorders / Acid Reflux	☐ YES	☐ NO
Diabetes (Insulin / Diet Controlled / Oral)	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Artificial Joints (Hip, Knee, etc.)	☐ YES	☐ NO
Head or Neck Injuries	☐ YES	☐ NO
Epilepsy, Convulsions (Seizures)	☐ YES	☐ NO
Viral Infections	☐ YES	☐ NO
Cold Sores / Fever Blisters	☐ YES	☐ NO
AIDS or HIV Infection	☐ YES	☐ NO
Sexually Transmitted Disease	☐ YES	☐ NO
Cortisone Medication	☐ YES	☐ NO
Cancer – Type: ________	☐ YES	☐ NO
Chemotherapy – Year: ________	☐ YES	☐ NO
Radiation Therapy – Year: ________	☐ YES	☐ NO
Emotional Problems	☐ YES	☐ NO
Psychiatric Treatment	☐ YES	☐ NO
Alcohol / Drug Dependency	☐ YES	☐ NO
Hearing Problems	☐ YES	☐ NO
Appetite Changes	☐ YES	☐ NO
Unexplained Weight Loss or Gain	☐ YES	☐ NO
H/O MRSA	☐ YES	☐ NO

Other Medical Conditions:

ARE YOU: (Please Check)

Question	YES	NO
Aware of any Change in your Health	☐ YES	☐ NO
Often Exhausted or Fatigued	☐ YES	☐ NO
Having Difficulty Sleeping	☐ YES	☐ NO
Having Night Sweats	☐ YES	☐ NO
Female – Pregnant / Nursing	☐ YES	☐ NO

Question	YES	NO
A Smoker – Packs per Day / Week / Duration: ________	☐ YES	☐ NO
Previous Y / N Quit Date: ________	☐ YES	☐ NO
Easily Upset or Irritated	☐ YES	☐ NO
Often Unhappy or Depressed	☐ YES	☐ NO

(continued on other side)

MEDICAL HISTORY (cont.)

DO YOU HAVE A HISTORY OF: (Please Check)

Eyelid Disease or Surgery ☐ RIGHT EYE ☐ LEFT EYE
Complications: ____________________

Tear Duct Surgery ☐ RIGHT EYE ☐ LEFT EYE
Complications: ____________________

Dry Eyes ☐ RIGHT EYE ☐ LEFT EYE
Complications: ____________________

Cataracts or Cataract Surgery ☐ RIGHT EYE ☐ LEFT EYE
Complications: ____________________

Glaucoma or Glaucoma Surgery ☐ RIGHT EYE ☐ LEFT EYE
Complications: ____________________

Cornea Disease or Surgery ☐ RIGHT EYE ☐ LEFT EYE
Complications: ____________________

Retina / Macular Disease or Surgery ☐ RIGHT EYE ☐ LEFT EYE
Complications: ____________________

Eye Infection or Injury ☐ RIGHT EYE ☐ LEFT EYE
Complications: ____________________

Family Eye Disease ☐ RIGHT EYE ☐ LEFT EYE
Complications: ____________________

Other: ____________________ ☐ RIGHT EYE ☐ LEFT EYE

PLEASE COMPLETE:

Please list any previous surgeries or hospitalizations with dates / complications: ____________________

Currecnt medication dose and how often. (Please include over the counter medications): ____________________

AUTHORIZATION / VERIFICATION:

Please advise us in the future of any change in your medical history or any medications you may be taking.

I understand the above information is necessary to provide me with care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

SIGNATURE: ____________________ DATE ____________

FOR DOCTOR'S USE ONLY

Doctor's Remarks: ____________________