** PLEASE COMPLETE AND BRING WITH YOU THE DAY OF YOUR SURGERY **

Patient Health and History - Spectra Eye Institute

Name: _____ Date: _____

Age: _____ Weight: _____ Height: _____ Contacts: ___Right___Left __None

Dentures: Upper ___Lower___ None___ Hearing Aids: Right___ Left___ None ____

Name of the person taking you home: _____ Relationship: _____

Home Phone: _____ Cell Phone _____

Person to notify in case of an emergency: _____ Relationship: _____

Home Phone: _____ Cell Phone _____

**PLEASE REMOVE ALL JEWELRY PRIOR TO ARRIVAL OR GIVE TO FAMILY MEMBER * *

Doctors: Please list all the main doctors involved in your care:

Name	Reason
_____	_____
_____	_____
_____	_____

Allergies: (list)	Type of Reaction	Are you sensitive to any of following?
_____	_____	Iodine: Topical ___ IV ___
_____	_____	Tape: Paper ____ Cloth ____
_____	_____	Latex ____ If so, reaction: _____
_____	_____	_____

(If more space is needed, please attach a separate sheet with list.)

Anesthesia Reactions:

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

Describe reaction: _____

Family member with complications related to anesthesia? Yes ____ No ____

MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY IN PAST OR PRESENT

Heart and Vascular
- __ Heart Attack(s) Date(s): _____
- __ Angina/Chest Pain
- __ Irregular Heart Beat/Murmur
- __ Abnormal Rhythm
- __ High Blood Pressure
- __ Heart Failure
- __ Pacemaker
- __ Mitral Valve Prolapse
- __ Other _____

Lungs
- __ Asthma/Wheezing
- __ Emphysema
- __ Bronchitis
- __ Bronchiectasis
- __ Chronic Cough
- __ TB (or family history)
- __ Shortness of Breath
- __ 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/Neck Trouble
- __ Arthritis
- __ Multiple Sclerosis
- __ Other _____

Other
- __ Glaucoma __ RT __ LT
- __ Hearing Loss __ RT __ LT
- __ Breast Feeding
- __ Cancer: Type _____
- __ Recent Cough/Cold
- __ Other _____

_____

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Type of Reaction

MEDICATIONS **I do not take any medications** _____

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

Name of Medicine	Doses of Medicine	How Often Taken

Over-the-counter Medications: Please check any that you take

__None __Antacids __Aspirin containing products __Cold/Cough Remedies
__Diarrhea Preparation __Eye Drops __Herbal Remedies __Laxatives __Pain Medicines
__Sleeping Medicine __Vitamin/Supplements __Recreational Drugs __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 Date Stopped: _____
If yes, name of drug: _____ For what? _____ Last dose: _____

Surgical History

List previous surgeries/injuries/hospitalizations or procedures (including eye surgeries):

Date: Procedures:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Other

Last Time you ate or drank: _____ am___pm ___
Do you use tobacco? __ Yes __ No Quit when? _____ Years of use: _____
Do you use alcohol? __ Yes __ No
Prosthetic devices: __Joint Replacements __ Lens Implants __Right __Left __ Other _____
Could you be pregnant? __ Yes __ No Last Menstrual Period _____

_____ _____ _____
Form Completed By Relationship Date

_____ _____
Signature of Patient or Guardian Date