Patient History

PLEASE COMPLETE AND BRING WITH YOU

Legal Name: _____ DOB: _____
Height: _____ Weight: _____ Sex: _____
Marital Status: Single___ Married ___ Divorced ___ Widowed ___
Occupation:_____Retired from:_____
Name of family physician: _____Phone: _____
Date of last visit: _____
List of surgeries in the last 5 years_____
_____

Do you have or have you ever had any of the following?

YES	NO	Diabetes (Controlled by Insulin, pills, diet)	YES	NO	Sleep apnea/Emphysema/Asthma
YES	NO	Heart Disease _____	YES	NO	Problem lying flat
YES	NO	High blood pressure	YES	NO	Claustrophobia/Anxiety
YES	NO	Chest pain / Angina	YES	NO	Use oxygen to sleep at night
YES	NO	Irregular heart rate or Pacemaker	YES	NO	Bleeding problems
YES	NO	Neurological disorders _____	YES	NO	Stomach ulcer/Hernia/Reflux
YES	NO	Kidney Failure / Dialysis	YES	NO	Take Flomax or Coumadin
YES	NO	Thyroid Disease _____	YES	NO	Wear a hearing aid Lt/Rt/Both
YES	NO	Hepatitis/AIDS/HIV/Tuberculosis	YES	NO	Problems with Anesthesia
YES	NO	Arthritis (type) _____	YES	NO	Smoke/Tobacco (how much)_____
YES	NO	Cancer (type) _____	YES	NO	Drink Alcohol (how much)_____
YES	NO	Dementia/Alzheimer's	YES	NO	Recreational drugs_____

Family History: Has anyone in your immediate family (parents, grandparents, brothers or sisters) had problems with any of the following?

Cataracts YES NO _____ Glaucoma YES NO _____
Retinal YES NO _____ Diabetes YES NO _____
Cancer YES NO _____ Macula Degeneration YES NO _____
Other _____

The information that I have given concerning my medical history is true and correct to the best of my knowledge. For my safety, I will obey all instructions and have responsible transportation and home care available.

Signature of patient or caregiver:_____Date:_____Time:_____