

# COMMONWEALTH EYE SURGERY PATIENT HISTORY

1. Patient Name: \_\_\_\_\_ Family Physician: \_\_\_\_\_ Phone# \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pharmacy: \_\_\_\_\_ Phone#: \_\_\_\_\_

2. Disease History: Do you smoke? ( ) No ( ) Yes \_\_\_\_\_ packs/day.  
Do you consume alcohol? ( ) No ( ) Yes How often? \_\_\_\_\_

Do you have or have you had any of the following:

- |                                 |   |                           |  |   |                                    |
|---------------------------------|---|---------------------------|--|---|------------------------------------|
| <b>a. Lung</b>                  | <b>b. Vascular</b>  | <b>c. CNS</b>             | <b>d. Endocrine</b>                        | <b>e. Other</b>   | <b>f. Eyes</b>                     |
| ( ) Bronchitis                  | ( ) High Blood Pressure   | ( ) Numbness/<br>Weakness | ( ) Diabetes                               | ( ) Bladder Problem   | ( ) Glaucoma                       |
| ( ) Emphysema                   | Is it under control?<br>Yes _____ No _____  | ( ) Menigitis             | Is it under control?<br>Yes _____ No _____ | ( ) Kidney  | ( ) Cataract                       |
| ( ) Asthma                      | ( ) Heart Attack  | ( ) Parkinsons            | I do not check _____                       | ( ) End Stage Renal Disease<br>On Dialysis?<br>Yes _____ No _____ | ( ) Macular<br>degeneration        |
| ( ) TB                          | ( ) Heart Murmur  | ( ) Migraines             | Year Diagnosed _____                       | If Yes, what days? _____  | ( ) Eye trauma/<br>Eye injury      |
| ( ) Sinusitis                   | ( ) Rheumatic Fever   | ( ) Seizures              | Blood Sugar Avg _____                      | ( ) Claustrophobia  | ( ) Eye turning in/out             |
| ( ) Cold or Resp.<br>Infections | ( ) Circulation Problem   | ( ) Alzheimers            | ( ) Thyroid Problems                       | ( ) Stomach   | ( ) Previous refractive<br>surgery |
| ( ) COPD                        | ( ) Heart Disease   | ( ) Depression            | ( ) Others-List<br>_____                   | ( ) Hiatal Hernia   | ( ) History of uveitis             |
| ( ) Home Oxygen                 | ( ) Chest Pain  | ( ) Anxiety               | _____                                      | ( ) Arthritis/Joint Pain  | ( ) History eye surgery            |
| ( ) Sleep Apnea                 | ( ) Sickle Cell   | ( ) Restless Leg Syndrome | _____                                      | ( ) GERD  | ( ) None                           |
| ( ) Use CPAP                    | ( ) Stroke  | ( ) None                  | ( ) None                                   | ( ) Bowel   |                                    |
| ( ) Any lung problem            | ( ) Cholesterol   |                           |  | ( ) Hepatitis   |                                    |
| ( ) None                        | ( ) Pacemaker and/or Defibrillator (AICD)<br>Has the unit been checked in the last 3 months?<br>Yes _____ No _____ Patient Initials _____<br>Please bring copy of cardiac implant card. |                           |  | ( ) Fainting  |                                    |
|                                 |   |                           |  | ( ) Weight change   |                                    |
|                                 |   |                           |  | ( ) HIV   |                                    |
|                                 |   |                           |  | ( ) Bleeding Problems/<br>Anemia/Blood Disorder                   |                                    |
|                                 |   |                           |  | ( ) Immune Deficiency   |                                    |
|                                 |   |                           |  | ( ) Skin rash/Change in moles                                     |                                    |
|                                 |   |                           |  | ( ) Shingles/Herpes   |                                    |
|                                 |   |                           |  | ( ) MRSA  |                                    |
|                                 |   |                           |  | ( ) Any medical condition<br>not listed above.                    |                                    |

3. Medical allergies and reaction NKDA (no known allergies) \_\_\_\_\_ LATEX Allergy? \_\_\_\_\_  
List: \_\_\_\_\_

4. Have you ever taken any medications for your prostate?  
( ) Tamsulosin (Flomax) ( ) Terazosin (Hytrin) ( ) Doxazosin (Cardura)  
( ) Afluzosin (Uroxatral) ( ) Siadosin (Rapaflo) ( ) Other \_\_\_\_\_

5. Personal History:  
a. Do you have any physical restrictions or limitations? \_\_\_\_\_ Can you lay flat? ( ) Yes ( ) No

b. Please circle any that apply to you: Loose teeth Dentures Bridges Capped teeth  
Hard of hearing Hearing aid

c. Do you wear contact lenses? ( ) No ( ) Yes Last date worn \_\_\_\_\_

d. List all previous surgeries on your body and include dates. \_\_\_\_\_

e. Have you or any of your relatives ever had a problem with anesthesia? ( ) Yes ( ) No

f. Do any living or deceased relatives have any of the following?

Diabetes ( ) No ( ) Yes Relation \_\_\_\_\_ High Blood Pressure ( ) No ( ) Yes Relation \_\_\_\_\_

Cancer ( ) No ( ) Yes Relation \_\_\_\_\_ Heart Disease ( ) No ( ) Yes Relation \_\_\_\_\_

Glaucoma ( ) No ( ) Yes Relation \_\_\_\_\_ Macular Degeneration ( ) No ( ) Yes Relation \_\_\_\_\_

g. Females Only: Are you pregnant at this time? ( ) Yes ( ) No Are you nursing? ( ) Yes ( ) No

Patient Initials \_\_\_\_\_ Date: \_\_\_\_\_