OCULOFACIAL PLASTIC SURGERY
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Name_____ Date _____

Any major surgeries or eye SURGERIES? ☐ No ☐ Yes; Please list:

1._____ 2. _____

3._____ 4. _____

List any **MEDICATIONS** you take now. Include all non-prescription drugs & vitamins

Name of medicine	Strength	How many?	Times a day?	Reason for taking
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Any **ALLERGIES** to medications? ☐ No ☐ Yes; Please list & what reaction:

1._____ 2. _____

3. _____ 4. _____

Allergic to: IV Dye? ☐ No ☐ Yes To Iodine? ☐ No ☐ Yes To Latex? ☐ No ☐ Yes

MEDICAL HISTORY Do you or your immediate family have any of the following:

Self	Family		Explain any checked items
☐	☐	Recurring fever	_____
☐	☐	Weight loss	_____
☐	☐	Ears/nose/throat (sinus, dry mouth etc)	_____
☐	☐	Heart (blood pressure, cholesterol etc)	_____
☐	☐	Respiratory (asthma, emphysema, etc)	_____
☐	☐	Gastrointestinal (ulcers, diarrhea etc)	_____
☐	☐	Kidney/bladder (kidney stones etc)	_____

Print Your Name_____ Date of Birth_____

Self	Family		Explain any checked items
☐	☐	Muscles, bones, joints (arthritis etc)	_____
☐	☐	Skin (eczema, rosacea, psoriasis etc)	_____
☐	☐	Neurological (stroke, multiple sclerosis)	_____
☐	☐	Psychiatric (anxiety, depression, etc)	_____
☐	☐	Endocrine (diabetes, hypothyroid, etc)	_____
☐	☐	Blood/lymph (cholesterol, anemia etc)	_____
☐	☐	Allergic/immunologic (lupus etc)	_____

SOCIAL history

Current occupation _____ Years _____ Employer _____

Do you drink alcohol? ☐ No ☐Occasional ☐ 1 per day ☐ 2-3 per day ☐4+ per day

Do you smoke? ☐ Never ☐ Previous User ☐ Current User

How many years of smoking? _____ Packs per day: _____ If previous, when? _____ years ago

EYE HISTORY Do you have any problems with:

Tired eyes/fatigue while ☐ Reading ☐ Driving ☐ Watching TV ☐ Other_____ ☐ None

Drooping eyelid(s)	☐ No ☐ Yes	_____
Loss of vision	☐ No ☐ Yes	_____
Double vision	☐ No ☐ Yes	_____
Glare/light sensitivity	☐ No ☐ Yes	_____
Headaches	☐ No ☐ Yes	_____
Dry, burning or gritty feeling	☐ No ☐ Yes	_____
Itching, watery eyes	☐ No ☐ Yes	_____
Eye pain or soreness	☐ No ☐ Yes	_____
Infection of eye/lid or stye	☐ No ☐ Yes	_____
Mucous discharge	☐ No ☐ Yes	_____
Redness	☐ No ☐ Yes	_____