ARIZONA OCULAR & FACIAL
Plastic Surgery

PATIENT HEALTH HISTORY

Please complete this form and bring with you to your appointment

NAME:_____

DOB:_____AGE:_____WEIGHT:_____HEIGHT:_____ DATE_____

Contacts? ❑ RIGHT ❑ LEFT HEARING AIDS? ❑ RIGHT ❑ LEFT DO YOU HAVE PAIN? YES / NO

PERSON TO NOTIFY IN CASE OF EMERGENCY:_____PHONE:_____RELATION:_____

DOCTORS

Please list all the doctors involved in your care.

NAME	REASON (ex. heart, diabetes)	PHONE #

MEDICATION ALLERGIES

❑ *NO KNOWN ALLERGIES*

NAME OF ALLERGY	TYPE OF REACTION

Are you sensitive to any of the following?

❑ Iodine ❑ topical ❑ injected IV

❑ Tape ❑ paper ❑ cloth

❑ Latex

Reaction:_____

ANESTHESIA REACTIONS:

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

Describe Reaction_____ Malignant Hyperthermia ❑ Yes ❑ No

Family Member with Complications Related to Anesthesia ❑ Yes ❑ No

Describe reaction

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

HEART AND VASCULAR

❑ Heart attack(s) DATE(s):_____
❑ Angina/ Chest Pain
❑ Murmur
❑ Abnormal Rhythm
❑ High Blood Pressure
❑ Heart Failure
❑ Pacemaker
❑ Mitral Valve Prolapse
❑ High Cholesterol
❑ Other:_____

LUNGS

❑ Asthma/Wheezing
❑ Emphysema
❑ Bronchitis
❑ Chronic Cough
❑ TB (or Family History)
❑ Shortness of Breath
❑ Recent Cough/Cold
❑ 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
❑ Hepatisis _____
❑ Anemia
❑ Bruising
❑ Other:_____

NERVOUS SYSTEM

❑ Stroke
❑ Seizures/Epilepsy
❑ Head/Neck Injury
❑ Other:_____

ENDOCRINE

❑ Diabetes
❑ Insulin
❑ Thyroid Disease
❑ Other:_____

MUSCULO-SKELETAL SYSTEM

❑ Chronic Back or Neck Trouble
❑ Arthritis
❑ Multiple Sclerosis
❑ Other:_____

OTHER

❑ Glaucoma ❑ Rt ❑ Lt
❑ Hearing Loss: ❑ Rt ❑ Lt
❑ Breast Feeding
❑ Cancer: Type:_____
❑ Pregnant
❑ Other:_____

_____

SIGNATURE OF PATIENT OR GUARDIAN DATE

Rev 06/16

PLEASE COMPLETE OTHER SIDE

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MEDICATIONS: ❑ ***I DO NOT TAKE ANY MEDICATIONS***

Please list all the medicines you take which require a doctor's prescription.

NAME OF MEDICINE	DOSE OF MEDICINE Mg, units, cc's	HOW OFTEN TAKEN

PLEASE CHECK ANY OVER-THE-COUNTER MEDICINES YOU ARE PRESENTLY TAKING:

- ❑ *NONE*
- ❑ Antacids
- ❑ Aspirin Containing Products
- ❑ Cold/Cough remedies
- ❑ Diarrhea Preparations
- ❑ Eye Drops
- ❑ Herbal Remedies
- ❑ Laxatives
- ❑ Pain Medicines
- ❑ Sleeping Medicine
- ❑ Vitamin/Supplements
- ❑ Recreational Drugs
- ❑ Weight Loss Medications
- ❑ ❑ Other: _____

Have you taken any blood thinner or aspirin in the last 3 months? ❑ **Yes** ❑ **No**

SURGICAL HISTORY:

LIST PREVIOUS SURGERIES/INJURIES/HOSPITALIZATIONS OR PROCEDURES (INCLUDE EYE SURGERIES) ❑ **NONE**

DATE	PROCEDURES
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____

SIGNATURE OF PATIENT OR GUARDIAN **DATE**