AESTHETIC EYE, PC

Oculofacial Plastic & Reconstructive Surgery

Patient Name: ______________________________ DOB: _____/_____/_____

Reason for visit: ______________________________

☐ Right Eye ☐ Left Eye ☐ Both Previous Treatment: ☐ Yes ☐ No

How long has the problem persisted: ______________________________

Do any of the following pertain to your health?

	NO	YES	Controlled by Medication	Explain
Neurological				
Headaches				
Paralysis/weakness				
Numbness or tingling				
Cardiovascular				
Heart disease/heart attack				
High blood pressure				
Bleeding and or clotting				
Stroke				
High cholesterol				
Chest pain				
Irregular heartbeat				
Pacemaker				
Congestive Heart Failure (CHF)				
Other heart problems				
Endocrine				
Diabetes (type I or II)				
Hypo thyroid				
Hyper thyroid				
Liver problems/disease				
Other endocrine problems				
Skin				
Scarring tendency/keloid former				
Skin cancer				
Infectious Disease				
HIV				
Hepatits (A, B, or C)				
History of MRSA				
Cancer				
Pregnant or nursing				

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	NO	YES	Controlled by Medication	Explain
Musculoskeletal				
Joint pain				
Artificial joints				
Limited motion				
Muscle weakness				
Constitutional Symptoms				
Epilepsy or seizures				
Fainting				
Fever or chills				
nausea, vomiting or diarrhea				
unexpected weight loss or gain				
Ear, nose, mouth and throat				
Sinus disorder				
Facial trauma or injury				
other ENT problems				
Genitourinary				
Bladder problems				
frequency/burning during urination				
Kidney problems				
Gastrointestinal				
Digestive problems				
Ulcers				
Other gastro Problems				
Hermatologic/Lymphatic				
Anemia				
Blood trasnfusion(s)				
Other blood problems				
Mental Health				
Depression				
Anxiety				
Parkinson's				
Alzheimer's/dementia				
Attention deficit disorder				
Development delay or disorder				
Other				
Respiratory				
Asthma/Sleep Apnea				CPAP USE?
Bronchitis/ Wheezing				
Emphysema/COPD				
Shortness of breath/Lung problems				
Pulmonary embolus				
Tuberculosis				

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PAST EYE HISTORY	YES	NO	EXPLAIN
Retinopathy			
Glaucoma			
Keratopathy			
Cataract			
Macular Degeneration			
Other			

SURGERIES/HOSPITALIZATIONS (INCLUDING EYES)

PROCEDURE	YEAR

FAMILY HISTORY	YES	NO	FAMILY MEMBER
NONE			
Unknown			
Autoimmune disorders			
Colon Cancer			
Diabetes			
Glaucoma			
High Blood Pressure			
High Cholesterol			
Liver Disease			
Lung Disease			
Malignant Melanoma			
Obesity			
Premature Coronary/Heart Disease			
Skin Cancer			
Thyroid Disease			

SOCIAL HISTORY	YES	NO	
Alcohol			☐ Daily ☐ Rarely ☐ Occasional
Smoke			☐ Quit Year: _____
Recreational Drug Use			☐ Quit Year: _____

Ht: _________ **Wt**: _________

Pharmacy: ______________________ **City**: ____________________

Cross Streets:____

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ALLERGIES

☐ NKDA ☐ NKA

MEDICATIONS

☐ NONE

PCP: ____ Cardiologist: _________________________________

Physician Name Physician Name

Other pertinent medical history (including laser treatments, peels, chemo, radiation, etc.):

____

____

I, ____, attest that the above health history, surgical history, allergies and medications are sccurate and the most up-to-date records I have. Should any of this information change while under the care of Dr. McInnes, I will notify this office promptly.

____ Date: _____/_____/_____

Patient Name