AESTHETIC EYE, PC

Oculofacial Plastic & Reconstructive Surgery

Today's Date: ____________________

Patient Information

Last Name	First Name	MI	Date of Birth
Mailing Address	City	State	Zip Code
( ) Primary Phone Number	( ) Secondary Phone Number	May we leave a message? Yes ☐ No ☐	
Email Address			
Preferred Language	Race	Ethnicity	
Occupation	Employer	Social Security Number	
Emergency Contact	( ) Phone Number	Relationship	

Did your physician refer you? If yes, whom? Yes ☐ No ☐ ____________________

May we discuss your medical information with anyone? Yes ☐ No ☐
If yes, whom? (please specify relationship) ____________________

Insurance Information

Primary Insurance Company	Policy ID Number
Policy Holder (full name as stated on insurance card)	Relation to Subscriber
Secondary Insurance Company	Policy ID Number
Policy Holder (full name as stated on insurance card)	Relation to Subscriber

How did you hear about us? Patient ☐ Social Media ☐ Other ☐

Would you like to receive promotional emails? Yes ☐ No ☐

Reason for visit						
			Duration			
Right Eye ☐	Left Eye ☐	Both ☐				
Have you had previous treatment for this condition?				Yes ☐	No ☐	
If yes, when and with who was treatment administered?						

Do you have or have you ever had any of the following? Please mark all either YES or NO.

	No	Yes	Controlled by Medication?	Explain
Neurological				
Headaches				
Paralysis/weakness				
Alzheimer's or Dementia				
Parkinson's Disease				
Numbness or tingling				
Other (please specify)				
Cardiovascular				
Heart disease/heart attack				
High blood pressure				
Bleeding/clotting disorder				
Stroke				
High cholesterol				
Chest pain				
Irregular heartbeat				
Pacemaker				
Congestive Heart Failure				
Other (please specify)				
Endocrine				
Diabetes (type I or II)				
Hypothyroid				
Hyperthyroid				
Liver problems/liver disease				
Other (please specify)				
Skin				
Do you have a tendenancy to scar or form keloids?				
Skin cancer (please state type and location)				
Infectious Disease				
HIV				
Hepatitis (A, B, or C)				
History of MRSA				
Cancer				
Pregnant or nursing?				

Do you have or have you ever had any of the following? Please mark all either YES or NO.

	No	Yes	Controlled by Medication?	Explain
Musculoskeletal				
Joint pain				
Artificial joints				
Limited motion				
Muscle weakness				
Other (please specify)				
Constitutional Symptoms				
Epilepsy or seizures				
Fainting				
Fever or chills				
Unexpected weight loss/gain				
Ear, nose, mouth, and throat				
Sinus disorder				
Facial trauma or injury				
Other (please specify)				
Urinary				
Bladder problems				
Frequent/burning urination				
Kidney problems				
Other (please specify)				
Gastrointestinal				
Digestive problems				
Ulcers				
Other (please specify)				
Hematologic and Lymphatic				
Anemia				
Have you ever had a blood transfusion(s)?				
Other (please specify)				
Mental Health				
Depression				
Anxiety				
Attention-deficit disorder				
Developmental delay or disorder				
Other (please specify)				
Respiratory				
Sleep Apnea (CPAP use?)				
Asthma				
Bronchitis/wheezing				
Emphysema/COPD				
Shortness of breath				
Pulmonary embolus				
Tuberculosis				

Do you have or have you ever had any of the following? Please mark all either YES or NO.

	No	Yes	Controlled by Medication?	Explain
Past Eye History				
Retinopathy				
Glaucoma				
Keratopathy				
Cataract				
Macular Degeneration				
Other (please specify)				

Surgeries or Hospitalizations	
Procedure	Year
Ocular Surgeries	

Family History			
	No	Yes	Family Member
Unknown or adopted			
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								
Alcohol Use	Yes ☐	No ☐	Daily ☐	Occasionally ☐	Rarely ☐
Smoking	Yes ☐	No ☐	Quit ☐	Year:	
Recreational Drug use	Yes ☐	No ☐	Quit ☐	Year:	

Patient's Pharmacy			
Name	Cross Streets	City	Phone Number

Current Medications		
Medication	Dosage	Prescribed by

Allergies	
Medication	Reaction
Latex allergy? Yes ☐	No ☐

Provider Information	
Primary Care Provider	
Cardiologist	

Other Medical History (including laser treatments, peels, chemotherapy, radiation, etc.)

Authorization	
To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that it is my responsibility to inform Aesthetic Eye, PC should any of the above information change.	
Signature of patient or responsible party (please state relationship)	Date
Name of patient or responsible party (please state relationship)	Date