

Your Name: _____

Date ___/___/___

Occupation: _____

Age _____

Symptoms you currently are or have recently been experiencing (please circle yes or no):

Watery eyes.....YES NO
Discharge from eyes.....YES NO
Sinus problems.....YES NO
Difficulty breathing through nose.....YES NO
Difficulty swallowing.....YES NO
Chest pain/angina.....YES NO
Frequent nose bleeds.....YES NO
Easy bruising.....YES NO

Abnormal bleeding tendency.....YES NO
Shortness of Breath:
Sitting.....YES NO
Walking around home.....YES NO
Walking stairs.....YES NO
Walking several blocks.....YES NO

Allergies:
Environmental/hay fever.....YES NO
Local anesthetic.....YES NO
Penicillin, sulfa, or other
antibiotics.....YES NO
Iodine/Betadine.....YES NO
Codeine or other narcotics.....YES NO
Describe drug allergies_____

Personal Medical History-Have you ever had (please circle yes or no):

Vision loss not correctable with glasses
or contacts.....YES NO
Glaucoma.....YES NO
Cataracts/cataract surgery.....YES NO
Retinal Disease.....YES NO
Asthma/emphysema.....YES NO
High Blood Pressure.....YES NO
Rheumatic Heart Disease.....YES NO

Heart murmur.....YES NO
Mitral valve prolapse.....YES NO
Other heart disease (heart attack, angina,
blocked heart vessels, heart failure) YES NO
Hepatitis, Jaundice or liver disease.. YES NO
Tuberculosis.....YES NO
AIDS or HIV infection.....YES NO
Diabetes.....YES NO

Graves Disease/thyroid problems.....YES NO
Problems with immune system.....YES NO
Anemia.....YES NO
Transfusion.....YES NO
Cancer.....YES NO
Cold sores or fever blisters.....YES NO
Skin cancer.....YES NO

Family History-Have your parents or siblings had (please circle yes or no):?

Diabetes.....YES NO

Thyroid disease.....YES NO

High blood pressure.....YES NO

Do you wear : Glasses for distance vision? YES NO Contact lenses? YES NO Have you been told you have "dry eyes" YES NO

Do you take artificial tears or other eye drops? YES NO Please list: _____

Have you every had: Chemical peel? YES NO Laser skin treatment? YES NO Botox? YES NO. Facial or eyelid surgery or any cosmetic
surgery? YES NO Specify (if yes):_____

List other surgeries you have had:_____

After surgery /injury do you develop: Pigmented scars? YES NO Large/thick/keloid scars? YES NO Any other scarring abnormality? YES NO

Have you ever had a tooth removed? YES NO If "yes", did you have unusual bleeding at that time? YES NO

Do you take aspirin or cousin drugs such as Advil, ibuprofen, Motrin, Naproxyn, Celebrex, or other non-steroidal anti-inflammatory drugs? YES NO

Medications you presently take (continue on back of form if needed): _____

Do you smoke cigarettes? YES NO. If "yes", how many packs a day and for how many years? _____

Any health problems not mentioned above: _____

Are you or could you possibly be pregnant? (QUESTION FOR WOMEN) YES NO

How many alcohol containing drinks do you have in an average week? _____

Do you live alone? YES NO Name of person living with you? (We prefer that patients have company for 24 hr. after surgery) _____

If you use skin care products, please list: _____

Have you been told to take antibiotics prior to dental or surgical procedures ? YES NO If yes, what drug and how do you take it. _____

Are you aware that results of medical treatment and surgery vary from patient to patient and cannot be guaranteed? YES NO

Would you like recommendations on improved appearance of your eyelids, face, or skin at the time of your consultation? YES NO If yes, please list any
specific areas of interest:_____

Signature:_____ Date:_____

Thank you for taking the time to accurately record your health history!

If you have an advanced medical directive (a "Living Will" or Durable Power of Attorney for Health Care), you may ask us to keep a copy in your medical record.

For office use only: _____

History reviewed: [] No changes [] Changes as noted above [] MD Signature: