TN OCULOPLASTICS

****MUST ANSWER FRONT AND BACK ENTIRELY ****

Patient Name: _____ Date of Birth: _____

Pharmacy Name, Phone Number and Address:_____
_____

Primary Care Physician:_____

Cardiologist Name and Number: _____

Fill out medication list including all over the counter medications and supplements with dosage (or bring list with you):

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Please circle if you take any of the following (If so, explain why):

Aspirin	**Pradaxa**	**Eliquis**
Coumadin/Warfarin	**Effient**	**Xarelto**
Plavix/Clopidogrel	**Lovenox**	**Ticlid**

Drug Allergies (Please list any symptoms):

_____ _____ _____ _____

Latex allergy: Yes or No (If yes, list symptoms) _____

Have you ever had any of the following? (Please circle. If yes, please explain):

Heart Disease: **Yes or No** _____
High Blood Pressure: **Yes or No** _____
Blood Clots: **Yes or No** _____
Stroke: **Yes or No** _____
Cancer: **Yes or No** _____
Skin Cancer: **Yes or No** _____
Hepatitis: **Yes or No** _____
Diabetes: **Yes or No Type 1 or Type 2** _____
Thyroid Problems: **Yes or No** _____
Glaucoma: **Yes or No Which eye:** _____
Retinal Detachment: **Yes or No Which eye:** _____
Emphysema, Asthma or COPD: (please circle one if apply) _____
Vertigo: **Yes or No** _____
Seizures: **Yes or No** _____
Sleep Apnea: **Yes or No** _____ **If yes, do you use a CPAP? Yes or No**
Restless Leg Syndrome: **Yes or No** _____
HIV/AIDS **Yes or No**_____
OTHER: _____

OVER

Please List any Surgeries (including eye surgeries) and year if known (or bring list):

_____ year _____
_____ year _____
_____ year _____
_____ year _____

Any history of MRSA (Staph Infection): Yes or No If yes, when? _____

Any implanted devices? Pacemaker, Defibrillator, or Stents?
If yes when?_____

Family Medical History (List any immediate family that applies):

Diabetes _____ Heart Disease _____
High Blood Pressure _____ Cancer _____

Do you have any of the following conditions?

Fatigue	yes or no		
Fever	yes or no	Irregular heart beat/palpitations	yes or no
Night Sweats	yes or no	Constipation	yes or no
Hearing Loss	yes or no	Diarrhea	yes or no
Cough	yes or no	Vomiting	yes or no
Wheezing	yes or no	Painful Urination	yes or no
Cold Intolerance	yes or no	Bloody Urine	yes or no
Heat Intolerance	yes or no	Rash	yes or no
Excessive Thirst	yes or no	Joint Pain	yes or no
Excessive Hunger	yes or no	Gait Disturbance	yes or no
Excessive Urination	yes or no	Joint Swelling	yes or no
Dizziness	yes or no	Muscle Weakness	yes or no
Headache	yes or no	Bleeding	yes or no
Emotional Changes	yes or no	Bruising	yes or no
Chest pressure/discomfort	yes or no	Environmental allergies	yes or no
		Food allergies	yes or no

Do you currently smoke? **yes or no**
Have you ever smoked in the past? **yes or no**
Do you consume alcohol? **yes or no**
If so how often? (Circle one) Daily, socially, occasionally, or rarely.
How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____

What is your pain scale for your associated reason for visit today? Please circle

No Pain									Severe Pain
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
☺										☹

Current Weight _____ **Current Height _____**
If known, most recent blood pressure: _____

Any Advance Directives (do not resuscitate or other directive) you would like us to have on file? Yes or No

Patient Signature: _____

Tennessee Oculoplastics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.