

# Eye Plastic Surgery Associates - Health History

Name: \_\_\_\_\_

Please list the following:

## Past Surgeries/Hospitalizations/Medical Conditions

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## Current Medical Conditions/Diseases

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Do you have diabetes?      YES      NO

## Medications

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Do you take aspirin?    YES      NO    How often? \_\_\_\_\_

## Social History

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Use of Alcohol: Never \_\_\_\_\_ Rarely \_\_\_\_\_ Moderate \_\_\_\_\_ Daily \_\_\_\_\_

Use of Tobacco: Yes      No      How Often? \_\_\_\_\_

## Allergies

Antibiotics      Yes    No  
If yes, what: \_\_\_\_\_

Morphine, Demerol    Yes    No  
or other narcotics  
If yes, what: \_\_\_\_\_

Anesthetics      Yes    No  
If yes, what: \_\_\_\_\_

Iodine or      Yes    No  
other antiseptics  
If yes, what: \_\_\_\_\_

Aspirin or      Yes    No  
other pain remedies  
If yes, what: \_\_\_\_\_

Latex      Yes    No

X  
\_\_\_\_\_  
Patient Signature, Parent or Guardian

\_\_\_\_\_  
Date