The Abel Center for Oculofacial Plastic Surgery

Medical History Form

Pharmacy: _____ Pharmacy Phone: (_____) _____ - _____

Pharmacy Address: _____

Current Medical Problems (please circle):

Diabetes High Blood Pressure Hypo/Hyperthyroidism Lung Condition (Asthma) Scarring/ Keloiding

High Cholesterol Heart Condition (ex: AFib) Allergies Arthritis Cancer Cataracts Glaucoma Blindness

Stroke Heart Attack
Other:_____

Past Surgical History (please list previous surgeries with date, ex: **Eye Surgery, Pacemaker, Bypass, Stent**):

_____

Family History (please circle):

Diabetes High Blood Pressure Hypo/Hyperthyroidism Lung Condition (Asthma) Scarring/ Keloiding

High Cholesterol Heart Condition (ex: AFib) Allergies Arthritis Cancer Cataracts Glaucoma Blindness

Stroke Heart Attack
Other:_____

Allergies (please list any allergies to **medications** and your **reaction** to the medication(s):

_____

Are you Taking a **Blood Thinner** (ex: Aspirin, Plavix, fish oil, Vit E)? **YES / NO** (please circle and list below):

_____

Medications (please list all **medications** and **supplements** you are taking, including **eye drops**):

Medication	Dosage	Frequency

Patient Name: _____ DOB: _____/_____/_____

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Review of Systems

Mark (**X**) next to the box if you are experiencing any of the following symptoms:

GENERAL	Yes	No	**RESPIRATORY**	Yes	No
Fever			Shortness of Breath		
Changes in Appetite			Asthma		
Weight Loss/Gain			Chronic Cough		
Fatigue			Allergies		
SKIN			**GASTROINTESTINAL**		
Rash/Hives			Nausea		
Itching/ Dryness			Vomiting		
Eczema			Diarrhea		
Psoriasis			Constipation		
Moles			Indigestion		
Lesions			Abdominal Pain		
EYES			**MUSCULOSKELETAL**		
Glasses or Contact Lenses			Muscle Weakness		
Pain			Joint Pain		
Redness			Stiffness		
Decreased Vision			**NEUROLOGICAL**		
Double Vision			Seizures		
Excessive Tearing			Fainting		
EAR/NOSE/THROAT			Migraines/Headaches		
Sinus Problems			Stroke		
Trouble Swallowing			Numbness		

Patient Name: _____ DOB: _____/_____/_____

Dizziness			**PSYCHOLOGICAL**		
Ringing in Ears			Anxiety		
Hearing Loss			Depression		
CARDIOVASCULAR			Mood Swings		
Chest Pain					
Swelling of Hands/Feet			**Weight: _____**		
Irregular Heartbeat			**Height: _____**		
Easy Bleeding			**Do you consume Alcohol?**		
Easy Bruising			**Do you currently Smoke?**		