PATIENT HEALTH HISTORY **EYE SURGERY CENTER AT THE BILTMORE**

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU ON THE DAY OF YOUR SURGERY.

NAME:_____AGE:_____WEIGHT:_____HEIGHT:_____

CONTACTS: ☐YES ☐NO ☐RIGHT ☐LEFT **DENTURES**: ☐UPPER ☐LOWER **HEARING AIDS**: ☐RIGHT ☐LEFT

Name of person taking you Home: _____Relationship:_____

Phone:_____ ☐ Cell phone ☐ Home ☐ Work

Person to notify in case of emergency:
_____Relationship:_____

Phone:_____ ☐ Cell phone ☐ Home ☐ Work

Doctors: Please list all the doctors involved in your care.

NAME	**REASON (ex. Heart, Diabetes)**
_____	_____
_____	_____
_____	_____

MEDICAL HISTORY: Please check all that apply in past or present

HEART AND VASCULAR
- ☐ Heart attack(s) (Dates): _____
- ☐ Angina/Chest Pain
- ☐ Murmur
- ☐ Abnormal Rhythm
- ☐ Coronary Disease
- ☐ High blood Pressure
- ☐ Heart Failure
- ☐ Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Other: _____

LUNGS
- ☐ COPD
- ☐ Asthma/Wheezing
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Broncheictasis
- ☐ Chronic cough
- ☐ TB (or Family History)
- ☐ Shortness of Breath
- ☐ Sleep Apnea

GENITAL/URINARY
- ☐ Kidney or Renal
- ☐ Last Day of Dialysis_____
- ☐ Other:_____

GASTRO-INTESTINAL
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Hiatal hernia/Reflux/ Gerd
- ☐ Other:_____

BLOOD AND COAGULATION
- ☐ Aids/HIV
- ☐ Hepatitis Type:_____
- ☐ Anemia (Low Blood Count)
- ☐ Bruising
- ☐ Other:_____

NERVOUS SYSTEM
- ☐ Stroke
- ☐ Seizures/Epilepsy
- ☐ Head/Neck Injury
- ☐ Restless Leg Syndrome

ENDOCRINE
- ☐ Diabetes
- ☐ Insulin
- ☐ Thyroid Disease
- ☐ Other:_____

MUSCULO-SKELETAL
- ☐ Chronic back/neck trouble
- ☐ Arthritis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis/ Osteopenia

OTHER
- ☐ Glaucoma ☐ Rt ☐ Lt
- ☐ Hearing Loss ☐ Rt ☐ Lt
- ☐ Cancer; Type:_____
- ☐ Recent cough/Cold
- ☐ Other:_____

_____

SURGICAL HISTORY
_____
_____
_____
_____
_____
_____
_____

ANESTHESIA REACTIONS: Have you had any complication related to anesthesia? □ No □ Yes

□ General □ Local

Describe reaction: _____

OTHER:

Yes NO

☐ ☐ Do you use tobacco? Quit when? _____ Years of use? _____
☐ Cigarettes _____ packs/day ☐ Cigars ☐ Pipe ☐ Chew

☐ ☐ Do you use alcohol? How much? _____ Last Drink? _____

☐ ☐ Could you be pregnant? Last menstrual Period _____

*** PATIENTS, PLEASE FILL OUT ONLY THE SHADED AREAS OF THIS FORM ***

ALLERGIES: (including medications, food , latex and iodine)	TYPE OF REACTION NOTED

Please list all medications including prescriptions (Examples: pills, inhalers, creams, shots), over the counter medications (Examples: aspirin, antacids, diet pills, herbals such as ginseng, gingko), vitamins and birth control medications. Include medications taken as needed (Example: nitroglycerin, inhalers).

Home Medications Name	Dose	Frequency (How often?)	Reason for Taking	Last Taken (date/time)

PLEASE NOTE: This organization and its providers are not responsible for medications ordered by other organizations or providers. The above is a list of your medication(s) provided to us by yourself or responsible adult.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE FORM COMPLETED BY

Pre-Op RN Signature: _____ Date/Time: _____

PATIENT MEDICATION RECONCILIATION FORM

If you are returning for a second surgery at this facility and there have been NO changes to your medications, you do not need to fill out this form. Please just sign and date:

Patient Signature:_____ Date:_____

Pre-Op RN Signature: _____ Date/Time: _____

New Prescription Added After Procedure	Dose	Frequency (How often?)	Reason for Taking

☐ Copy given to patient upon discharge by: Nurse Signature: _____ Date/Time: _____

☐ Copy given to patient upon discharge by: Nurse Signature: _____ Date/Time: _____