

Eagle Eye Surgery and Laser Center		Patient Name:	
Surgery Date:		Date of Birth:	
Primary Care Physician:		PCP Phone Number:	
Past Medical History			
Check appropriate Yes/No responses and circle all types that apply.			Explain with dates if known
Yes	No	Heart problems?	Types: Heart attack, heart failure, chest pains, pacemaker, pacemaker with defibrillator (<i>if defibrillator, card should be sent to ASC prior to surgery, for instructions for surgery</i>) heart valve problems, other?
Yes	No	Blood pressure problems?	On treatment plan, advised to be on treatment but not currently on plan, never been told B/P was an issue
Yes	No	Respiratory Problems	Types: Asthma, emphysema, sleep apnea, CPAP, severe snoring, home oxygen _____liters, recent cold or cough, shortness of breath with exercise or lying flat.
Yes	No	Tobacco Use	Have you ever or do you currently use tobacco? Cigarette, cigar, chewing tobacco If you quit, when _____
			Amount per day _____ # years used _____
Yes	No	Thyroid/Gland problems?	Type?
Yes	No	Diabetes or blood sugar problems	How is it controlled? Diet/exercise, oral pills, insulin
Yes	No	Kidney problems? (males only -prostate problems)	Ever used a medication called Flomax?
Yes	No	Frequent heartburn, ulcers or other stomach or esophagus problems?	Reflux?
Yes	No	Liver problems?	Types: hepatitis ____, cirrhosis, other?
Yes	No	Muscle or bone problems?	Type: neck problems, back problems, arthritis, osteoporosis, polio, fibromyalgia
Yes	No	Neurological problems?	Types: stroke, seizures, Parkinson's disease, headaches, nerve damage, MS
Yes	No	Clotting Problems?	Types: blood clots in legs or lungs Use of blood thinners
Yes	No	(Females only) Is there a chance you could be pregnant?	Last menstrual period _____ Hysterectomy?

Name				
Yes	No	Are there any other medical conditions you haven't listed?		
Yes	No	Do you have any loose teeth, bridgework, caps, or dentures?		
Yes	No	Have you or a family member had problems with anesthesia		
List meds and dosages you use. Include over the counter meds)	Medication	Dose	Medication	Dose
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
List any allergies & reactions	Medication Allergy	Reaction	Food /Other Allergy	Reaction
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Previous Surgeries				
Signature of person completing this form		Relationship	Date	
Following sections for ophthalmologist use: Height _____ Weight _____ Actual/Stated			Following section for Anesthesia Use	
B/P _____/____ if over 150/90 repeat _____/_____			NPO since:	
Pulse _____			Airway exam:	
Heart _____			FBS _____	
Yes	No	Regular Rhythm	Lab results if clinically applicable Comments:	
Yes	No	Murmors/rubs		
Lungs				
Yes	No	Lungs Clear		
Neuro _____			ASA Class I II III	
Yes	No	Alert & Oriented x 3		
Comments:			Risks, benefits and options for anesthesia have been reviewed. (See detailed anesthesia consent). Questions were answered. Patient wishes to proceed. Anesthesia plan collaborated with MD.	
Surgeon Signature			Anesthesia Signature	
Date			Date	
History reviewed without changes			History reviewed without changes	
Surgeon Signature			Anesthesia Signature	
Date:			Date:	