

PATIENT HISTORY RECORD

Date (MM/DD/YYYY) ___/___/200___ Patient's Name: _____ Birth Date: ___/___/___
First M.I. Last

Review of Systems:

Eyes – Please briefly explain the nature of today's visit: _____

(Please read each of the questions *carefully* and answer each completely. Please check 'no' if you do not have any of the following problems. Your answers are an important part of your medical and surgical care. If you have any questions of difficulties, please ask our staff or Dr. Klapper for assistance. Please sign page 2 of the History Record once you have completed the questionnaire. Thank you.)

Do you currently have any of the following medical problems? Yes No If yes, please explain:

Eyes (e.g., decreased vision, double vision, watery eyes, eye pain)_____

Ear/nose/throat (e.g., hearing loss, sinus problems, sore throat)_____

Heart (e.g., high blood pressure, chest pain, irregular heart beat, pacemaker).........._____

Respiratory_____
(e.g., shortness of breath, wheezing, persistent cough > 3 weeks, bloody sputum)

Gastrointestinal_____
(e.g., heartburn, ulcer problems, abdominal pain, diarrhea, constipation, vomiting, blood in stool, loss of bowel control)

Genital/Urinary_____
(e.g., pain on urination, blood in urine, kidney problems, prostate problems, sexually transmitted disease, genital problems)

Skin or Breast_____
(e.g., rash, excessive dryness, skin allergies, skin tumors on face or elsewhere, breast discharge)

Musculoskeletal_____
(e.g., muscle aches, joint pain, pain when chewing, scalp pain or tenderness, swollen joints)

Neurologic (e.g., numbness, weakness, headaches, paralysis, speech difficulty),....._____

Endocrine/Hormone_____
(e.g., Diabetes, heat/cold intolerance, tremulousness, change in voice, change in hat/shoe size, increased thirst, increased urination)

Cancer/Blood.........._____
(e.g., cancer of any kind, radiation, chemotherapy, anemia, slow blood clotting, excessive bruising, swollen glands)

Allergy/Immunology.........._____
(e.g., HIV positive, hayfever, shellfish allergy, allergy to injected contrast dyes, arthritis, lupus)

Psychiatric (e.g., depression, anxiety, mood swings)_____

Chronic fever, unexpected weight loss/gain, fatigue, night sweats......._____

Past Medical History (please write 'none' under each category if it does not apply to you) [ROS ___/14]

Please list any **eye problems, surgeries, or injuries:**

Please list all **medications** and dosages:

Please list other **medical conditions:**

Please list all other **surgeries** and/or hospitalizations:

Please list all **medication allergies** (e.g., rash, difficulty breathing)

Patient Name: _____

PATIENT HISTORY RECORD

Pre-Surgical (It is critical that you completely answer these questions if you are considering any form of eyelid or facial surgery)

How often do you take aspirin? never occasionally daily – how much? _____

Do you take vitamins or herbal supplements: never occasionally daily – what type? _____

Do you bruise or bleed easily? yes no Difficulty healing after surgery? yes no If yes, explain _____

Have you ever had a problem with an anesthetic used during surgery? yes no If yes, explain _____

Are you HIV positive? yes no Have you been diagnosed with Hepatitis? yes no

Do you have active or latent Tuberculosis (TB)? yes no

When was your last physical exam? _____ By whom? _____

(A copy of your most recent history and physical exam, cardiology examination, and EKG may be requested prior to surgery)

When was your last eye exam? _____ By whom? _____

Social History

Do you smoke? yes no If so, how much per day? _____

Did you smoke in the past and then quit? yes no If so, when did you quit? _____
Congratulations!!

Are you employed: yes no What is/was your occupation? _____

What is your marital status: single married widowed separated divorced

If married, what is your spouse's occupation? _____

Family History

Do any medical or eye diseases run in your family? yes no If yes, please describe _____
(e.g., diabetes, high blood pressure, heart disease, cancer, thyroid disease, mental disease, droopy eyelids, glaucoma, cataracts)

Family Member	Age	Current health or cause of death	Family Member	Age	Current health or cause of death
Mother	_____	_____	Brother 1.....	_____	_____
Father.....	_____	_____	Brother 2.....	_____	_____
Child 1.....	_____	_____	Sister 1.....	_____	_____
Child 2.....	_____	_____	Sister 2.....	_____	_____
Child 3.....	_____	_____	Other.....	_____	_____

PATIENT SIGNATURE: X _____

Office Use Only

Additional History Considered Pertinent by Physician:

PHYSICIAN'S SIGNATURE: X _____

DATE: ____/____/200____ (Stephen R. Klapper, M.D., F.A.C.S)

Updated/Reviewed ____/____/200____ by _____	Updated/Reviewed ____/____/200____ by _____
Updated/Reviewed ____/____/200____ by _____	Updated/Reviewed ____/____/200____ by _____
Updated/Reviewed ____/____/200____ by _____	Updated/Reviewed ____/____/200____ by _____

ROS: Prob pertinent (1) – L2	Extended (2-9) – L3	Complete (≥10/13) – L4	<i>Office Use Only</i>
PFSH: Pertinent (1/3) – L3	Complete (2/3 – established pt) – L4	Complete (3/3 – new pt) – L4	