# Beach Eye Medical Group

## Health History Questionnaire

Name: _____ **M / F** Age:____ Wt:____ Ht:_____
Date of Birth(*dd/mm/yyyy*): ___/____/_____

Do you wear? *(Circle one)*
**Contacts:** Y N Left/Right/Both **Dentures:** Y N **Hearing Aids**: Y N Left/Right/Both

**Allergies** to Medications: _____
*(Please list)* _____
**Allergies** to Foods, Tape, Soap, LATEX, etc: _____
*(Please list)*
Who will take you home? _____Relationship:_____ Phone#_____

**Current Medications –** (*please attach list if necessary)*

| Medication | Dose/Mg | X per day | Medication | Dose/Mg | X per day |
|---|---|---|---|---|---|
| 1. | | | 7. | | |
| 2. | | | 8. | | |
| 3. | | | 9. | | |
| 4. | | | 10. | | |
| 5. | | | 11. | | |
| 6. | | | 12. | | |

Have you or a blood relative ever had a complication with anesthesia? ☐ Yes ☐ No
describe_____

List any Previous Surgeries and the dates or years of the surgeries: _____
_____
_____
_____

**Medical History** *(Check all that apply to you)*

**Cardiac**
☐ Angina/Chest Pain
☐ Congestive Heart Failure
☐ Irreg. Heart Beats
☐ Coronary Bypass #___
☐ High Blood Pressure
☐ Pacemaker

**Lungs**
☐ Asthma/Use Inhalers
☐ Emphysema
☐ COPD/Use Oxygen at home?
☐ Bronchitis
☐ Allergies
☐ Sleep Apnea/Wear CPAP?
☐ Smoker, Pks per Day

**Thyroid**
☐ Hyperthyroid
☐ Hypothyroid

**Eyes**
☐ Glaucoma ☐ Cataract surgery
☐ Retina surgery

**Kidney**
☐ Chronic Urinary Tract Inf.
☐ Dialysis, When_____
☐ Voiding at Night #_____

**Liver**
☐ Hepatitis A,B,or C
☐ Cirrhosis

**Diabetics**
☐ Oral Meds
☐ Insulin Reg/NPH
☐ Diet Controlled

**Central Nervous System**
☐ Stroke/TIA's
☐ Seizures/Migraines

**Preganancy Screen**
☐ Possibilitly that you might be pregnant? If yes, please speak with surgeon

**Other**
☐ Alcohol Use
☐ How Often____
☐ Drug Use
Specify_____
☐ Bleeding Disorders
☐ History of Mental Illness
☐ **Take/Have taken FLOMAX**

**PATIENT STICKER**

**Patient/Guardian Signature:_____ Date_____**

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