OCULOFACIAL AESTHETICS

General Health History Questionnaire		
Patient name: _____	DOB: _____	Date:_____

Please tell us about your current or past health conditions by checking the boxes					
Please answer all questions	Y	N	Please answer all questions	Y	N
Cardiovascular			**Endocrine/Rheumatologic Continued**		
Coronary Artery Disease			Scleroderma		
Angina/chest pain			Rheumatoid arthritis		
History of heart attack (MI)			**Musculoskeletal**		
Congestive heart failure			Arthritis		
Heart valve disease/murmur			Chronic back pain		
Irregular heart rhythm			Chronic neck pain		
Have pacemaker			Restless leg syndrome		
Blocked circulation to extremities			Scoliosis		
Blocked carotid arteries			Joint replacement, knee (R/L)		
Clotting Disorders			Joint replacement, hip (R/L)		
Take aspirin daily			**Psychological**		
Take NSAIDs (ibuprofen/naproxen)			Dementia		
Take blood thinners			Alzheimer disease		
Respiratory			Bipolar disorder		
Asthma			History of stroke		
Emphysema/COPD			Seizure disorder		
Chronic bronchitis			Fibromyalgia		
Recent respiratory infection			**Women only**		
Pneumonia			Pregnant		
Tuberculosis			Breast-feeding		
Obstructive sleep apnea			Hysterectomy		
Use CPAP machine at night			**Other**		
Regular oxygen use			Slow or poor wound healing		
Kidney/Bladder			Cold sores, herpes, shingles		
Renal insufficiency			Skin cancer/type		
Kidney failure requiring dialysis			Other cancer, type		
Missing one kidney/kidney transplant/extra kidney			Psoriasis, eczema, other skin disorder		
Incontinent of urine			MRSA, VRE, other infection		
Frequent infections			Hepatitis		
Endocrine/Rheumatologic Continued			HIV		
Diabetes controlled with insulin			Problems undergoing general anesthesia		
Diabetes controlled with oral meds			Problems undergoing conscious sedation		
Diabetes controlled with diet			Problems undergoing local anesthesia		
Lupus			Take medication for weight loss		
Thyroid Disease					

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Please tell us about any surgeries on your eyes, eyelids or face			
Eye, Eyelid or Face Surgery	**Surgery site**	**Year of surgery**	**Surgeon of facility**

Please circle any of the following symptoms if they are new	
General	diarrhea / vomiting / weight loss (unintentional) / fever
Ears	difficulty hearing / deafness
Neurologic	numbness / seizures / dizziness, weak limbs (paresis)
Cardiovascular	chest pain / palpitations
Musculoskeletal	muscle pains / joint pains / back pain
Respiratory	cough / wheezing / sleep apnea
Allergy/Immunologic	runny nose / sinus pressure / itching
Endocrine	prominent eyes / muscle weakness
Blood/hematologic	easy bleeding / easy bruising / frequent nose bleeds
Eye	Discomfort / itching / double vision

Please tell us about your family's health history by checking the boxes			
	Diabetes	**Thyroid problems**	**High blood pressure**
Father			
Mother			
Brother/Sister			
Brother/Sister			

Please tell us about your social habits by checking the boxes			
Smoking	Yes	No	Current amount, how many years:
Alcohol	Yes	No	Current amount
Drug use	Yes	No	Drug, frequency:

Please tell us about your allergies or sensitivities to medications	
Allergy/Sensitivity	Reaction

List below all medications, supplements, vitamins, minerals and herbal supplements you take		
Medication name	Dose	Frequency (daily, twice daily, etc.)