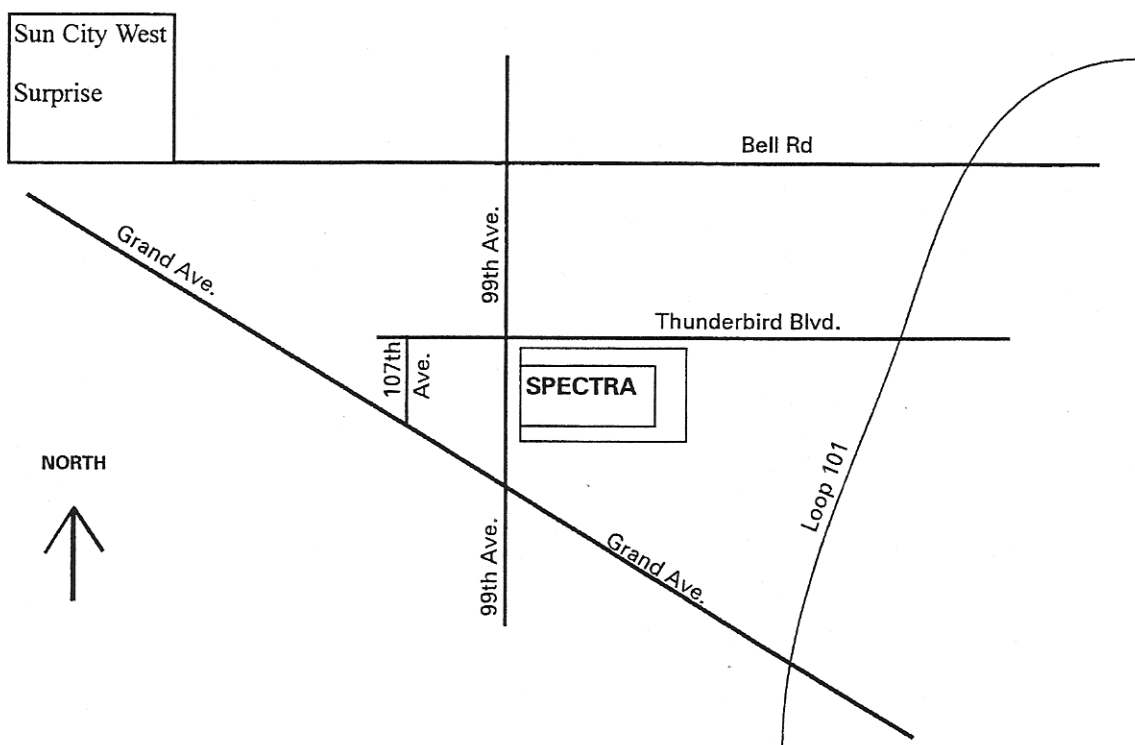


Important Information:

Date of Surgery: _____

Check-in Time: _____



Spectra Eye Institute, P.L.C.
9849 West Thunderbird Boulevard
Sun City, AZ 85351
(623) 583-2020

Patient Health and History – Spectra Eye Institute

Name: _____ Date: _____
 Age: _____ Weight: _____ Height: _____ Contacts: Yes No Right Left
 Dentures: Upper Lower Hearing Aids: Right Left
 Name of the person taking you home: _____ Relationship: _____
 Home Phone: _____ Cell Phone _____
 Person to notify in case of an emergency: _____ Relationship: _____
 Home Phone: _____ Cell Phone _____

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

Name	Reason
_____	_____
_____	_____
_____	_____

Allergies:	No Known Allergies <input type="checkbox"/>	Are you sensitive to any of the following?
Name	Type of Reaction	
_____	_____	Iodine <input type="checkbox"/> - Topical <input type="checkbox"/> IV <input type="checkbox"/>
_____	_____	Tape <input type="checkbox"/> - Paper <input type="checkbox"/> Cloth <input type="checkbox"/>
_____	_____	Latex <input type="checkbox"/> If so, reaction: _____
_____	_____	_____

(If more space is needed, please attach a separate sheet with list.)

Anesthesia Reactions:

Have you had any complication related to anesthesia? Yes No General Local

Describe reaction: _____

Family member with complications related to anesthesia? Yes No

MEDICAL HISTORY: PLEASE CHECK ALL THAT APPLY IN PAST OR PRESENT

<p>Heart and Vascular</p> <p><input type="checkbox"/> Heart Attack(s) Date(s): _____</p> <p><input type="checkbox"/> Angina/Chest Pain</p> <p><input type="checkbox"/> Irregular Heart Beat/Murmur</p> <p><input type="checkbox"/> Abnormal Rhythm</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Heart Failure</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Mitral Valve Prolapse</p> <p><input type="checkbox"/> Other _____</p> <p>Lungs</p> <p><input type="checkbox"/> Asthma/Wheezing</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Broncheictasis</p> <p><input type="checkbox"/> Chronic Cough</p> <p><input type="checkbox"/> TB (or family history)</p> <p><input type="checkbox"/> Shortness of Breath</p> <p><input type="checkbox"/> Sleep Apnea</p> <p><input type="checkbox"/> Other: _____</p>	<p>Genital/Urinary</p> <p><input type="checkbox"/> Kidney or Renal</p> <p><input type="checkbox"/> Dialysis/Schedule _____</p> <p><input type="checkbox"/> Other: _____</p> <p>Gastro-Intestinal</p> <p><input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Hiatal Hernia/Reflux</p> <p><input type="checkbox"/> Other: _____</p> <p>Blood and Coagulation</p> <p><input type="checkbox"/> Aids/HIV</p> <p><input type="checkbox"/> Hepatitis Type: _____</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Bruising</p> <p><input type="checkbox"/> Other _____</p> <p>Nervous System</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Seizures/Epilepsy</p> <p><input type="checkbox"/> Head/Neck Injury</p> <p><input type="checkbox"/> Other: _____</p>	<p>Endocrine</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Insulin</p> <p><input type="checkbox"/> Thyroid Disease</p> <p><input type="checkbox"/> Other _____</p> <p>Musculo-Skeletal System</p> <p><input type="checkbox"/> Chronic Back/Neck Trouble</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Other _____</p> <p>Other</p> <p><input type="checkbox"/> Glaucoma <input type="checkbox"/> RT <input type="checkbox"/> LT</p> <p><input type="checkbox"/> Hearing Loss <input type="checkbox"/> RT <input type="checkbox"/> LT</p> <p><input type="checkbox"/> Breast Feeding</p> <p><input type="checkbox"/> Cancer: Type _____</p> <p><input type="checkbox"/> Recent Cough/Cold</p> <p><input type="checkbox"/> Other _____</p>
---	--	---

MEDICATIONS I do not take any medications _____

Please list all of the medications of which you take that require a doctor's prescription

Name of Medicine	Doses of Medicine	How Often Taken

Over-the-counter Medications: Please check any that you take

None Antacids Aspirin containing products Cold/Cough Remedies
 Diarrhea Preparation Eye Drops Herbal Remedies Laxatives Pain Medicines
 Sleeping Medicine Vitamin/Supplements Recreational Drugs Other: _____

Have you taken cortisone or other steroid medicine in the last year? Yes No

If yes, name of drug: _____ For what? _____

Have you taken any anticoagulant (blood thinner or aspirin) medicine in the last 3 months?

Yes No Date Stopped: _____

If yes, name of drug: _____ For what? _____ Last dose: _____

Surgical History

List previous surgeries/injuries/hospitalizations or procedures (including eye surgeries):

None

Date:

Procedures:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other

Do you use tobacco? Yes No Quit when? _____ Years of use: _____

Do you use alcohol? Yes No

Prosthetic devices: Joint Replacements Lens Implants Right Left Other _____

Could you be pregnant? Yes No Last Menstrual Period _____

Form Completed By

Relationship

Date

Signature of Patient or Guardian

Date