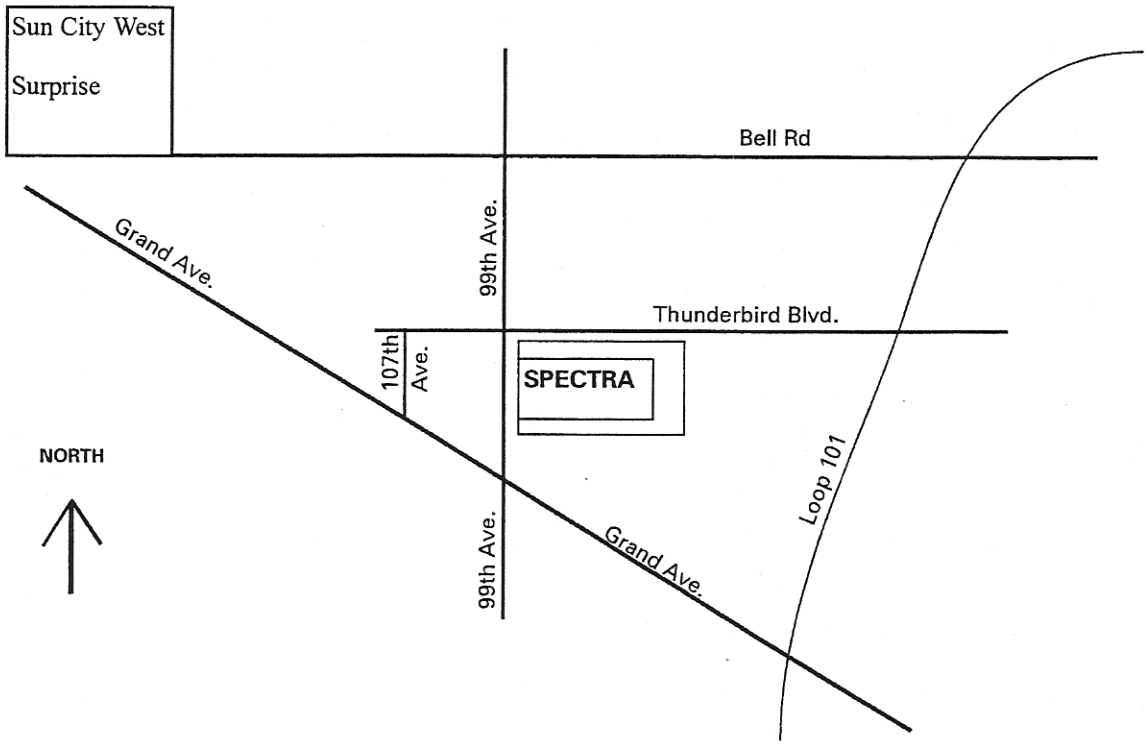
Important Information:

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 __

Name	Type of Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you sensitive to any of the following?
Iodine___ - Topical___ IV ___
Tape____ - Paper ___ Cloth____
Latex ___ 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

Heart and Vascular
__ Heart Attack(s) Date(s): _____
__ Angina/Chest Pain
__ Irregular Heart Beat/Murmur
__ Abnormal Rhythm
__ High Blood Pressure
__ Heart Failure
__ Pacemaker
__ Mitral Valve Prolapse
__ Other _____

Lungs
__ Asthma/Wheezing
__ Emphysema
__ Bronchitis
__ Broncheictasis
__ Chronic Cough
__ TB (or family history)
__ Shortness of Breath
__ Sleep Apnea
__ Other: _____

Genital/Urinary
__ Kidney or Renal
__ Dialysis/Schedule_____
__ Other: _____

Gastro-Intestinal
__ Liver Disease
__ Jaundice
__ Hiatal Hernia/Reflux
__ Other: _____

Blood and Coagulation
__ Aids/HIV
__ Hepatitis Type: _____
__ Anemia
__ Bruising
__ Other _____

Nervous System
__ Stroke
__ Seizures/Epilepsy
__ Head/Neck Injury
__ Other:_____

Endocrine
__ Diabetes
__ Insulin
__ Thyroid Disease
__ Other _____

Musculo-Skeletal System
__ Chronic Back/Neck Trouble
__ Arthritis
__ Multiple Sclerosis
__ Other _____

Other
__ Glaucoma __ RT __ LT
__ Hearing Loss __ RT __ LT
__ Breast Feeding
__ Cancer: Type_____
__ Recent Cough/Cold
__ Other_____
_____

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