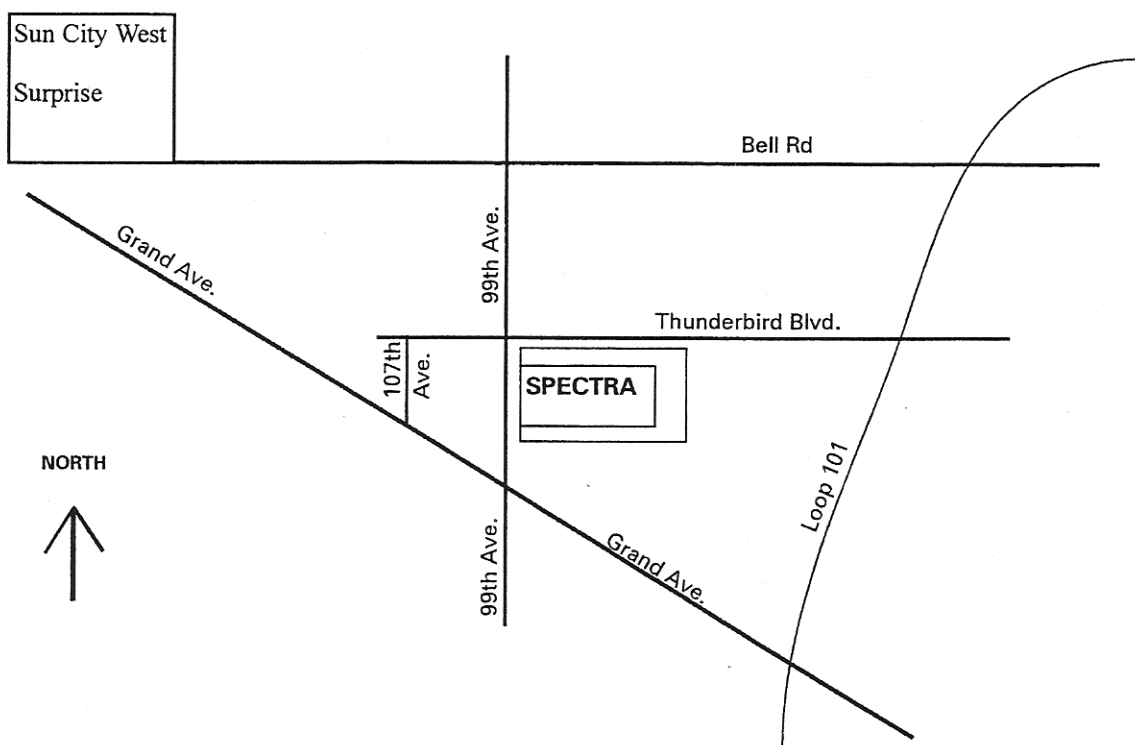


# Important Information:

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: Name	No Known Allergies <input type="checkbox"/> Type of Reaction	Are you sensitive to any of the following? 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**

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