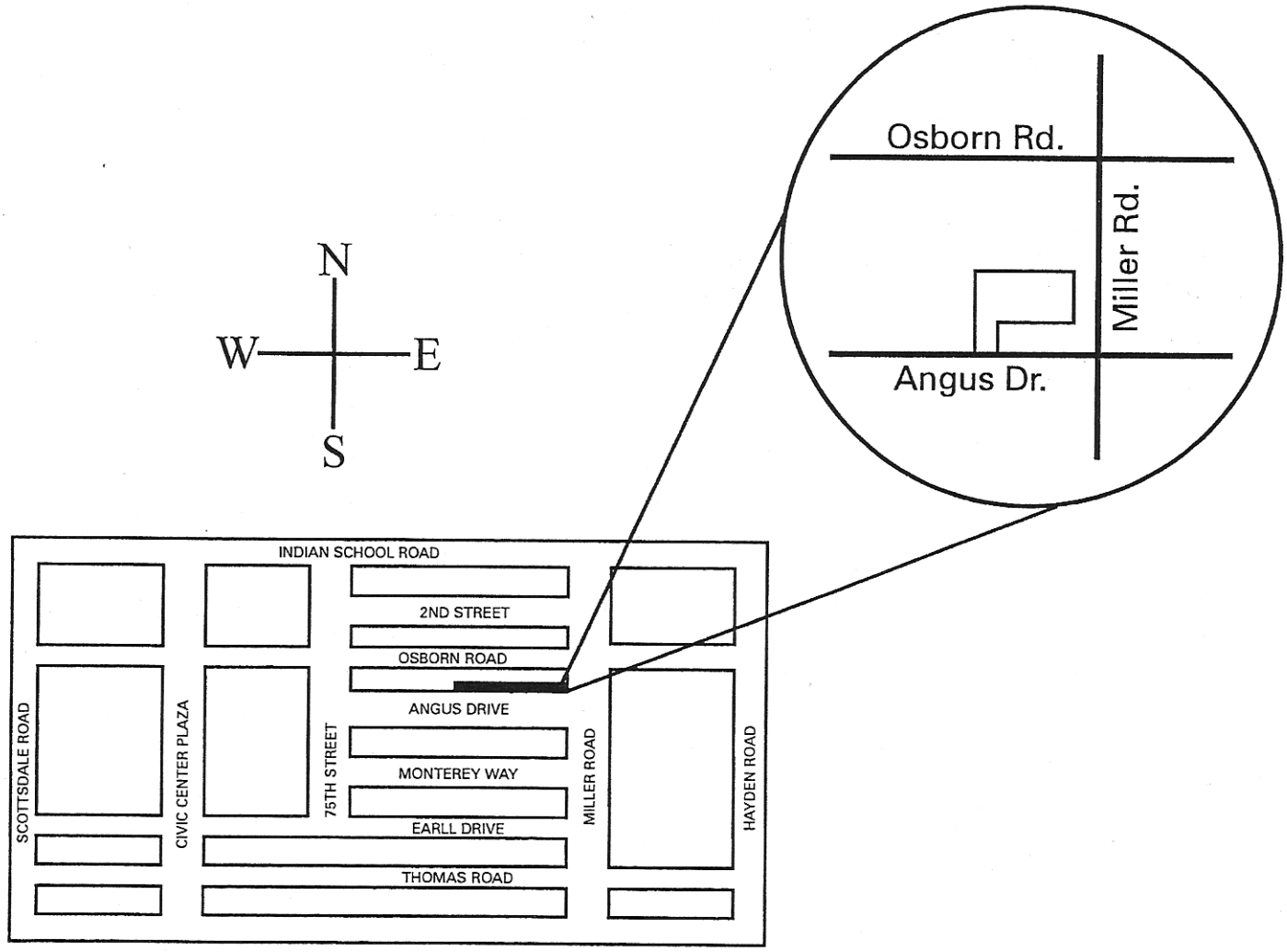
Important Information:

Date of Surgery: _____

Check-in Time: _____



Scottsdale Eye Surgery Center, P.C.
3320 North Miller Road
Scottsdale, AZ 85251
(480) 949-1208

PATIENT HEALTH HISTORY SCOTTSDALE EYE SURGERY CENTER, P.C.

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU ON THE DAY OF YOUR SURGERY.

NAME:_____ DATE:_____

AGE:_____ WEIGHT:_____ HEIGHT:_____ CONTACTS: ❑ RIGHT ❑ LEFT

DENTURES: ❑ UPPER ❑ LOWER HEARING AIDS: ❑ RIGHT ❑ LEFT

Name of person taking you home:_____

RELATIONSHIP:_____ PHONE #:_____

PERSON TO NOTIFY IN CASE OF EMERGENCY:_____ PHONE #:_____

DOCTORS

Please list all the doctors involved in your care.

NAME	REASON (ex. heart, diabetes)	PHONE #

MEDICATION ALLERGIES

❑ NO KNOWN ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION

Are you sensitive to any of the following?

❑ Iodine - ❑ topical - ❑ injected IV

❑ Tape - ❑ paper - ❑ cloth

❑ Latex

Reaction:_____

ANESTHESIA REACTIONS

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

Describe reaction_____

Malignant Hyperthermia ❑ Yes ❑ No

Family Member with Complications Related to Anesthesia ❑ Yes ❑ No

Describe Reaction_____

MEDICATION HISTORY PLEASE CHECK ALL THAT APPLY

HEART AND VASCULAR
- ❑ Heart Attack(s) (Dates):_____
- ❑ Angina/Chest Pain
- ❑ Irregular Heart Beat/Murmur
- ❑ Abnormal Rhythm
- ❑ High Blood Pressure
- ❑ Heart Failure
- ❑ Pacemaker
- ❑ Mitral Valve Prolapse
- ❑ Other:_____

LUNGS
- ❑ Asthma/Wheezing
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Chronic Cough
- ❑ TB (or Family History)
- ❑ Shortness of Breath
- ❑ Recent Cough/Cold
- ❑ 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/Epliepsy
- ❑ Head/Neck Injury
- ❑ Other:_____

ENDOCRINE
- ❑ Diabetes
- ❑ Insulin
- ❑ Thyroid Disease
- ❑ Other:_____

MUSCULO-SKELETAL SYSTEM
- ❑ Chronic Back or Neck Trouble
- ❑ Arthritis
- ❑ Multiple Sclerosis
- ❑ Other:_____

OTHER
- ❑ Glaucoma ❑ Rt ❑ Lt
- ❑ Hearing Loss: ❑ Rt ❑ Lt
- ❑ Breast Feeding
- ❑ Cancer: Type_____
- ❑ Pregnant
- ❑ Other:_____

_____ DO NOT WRITE IN THIS SPACE

FORM COMPLETED BY / RELATIONSHIP DATE

SIGNATURE OF PATIENT OR GUARDIAN DATE

PLEASE COMPLETE OTHER SIDE

SCOTTSDALE EYE SURGERY CENTER, P.C.

MEDICATIONS: ❑ *I DO NOT TAKE ANY MEDICATIONS*

Please list all the medicines you take which require a doctor's prescription.

NAME OF MEDICINE	DOSE OF MEDICINE	HOW OFTEN TAKEN

PLEASE CHECK ANY OVER-THE-COUNTER MEDICINES YOU ARE PRESENTLY TAKING:

❑ *NONE*
❑ Antacids
❑ Aspirin Containing Products
❑ Cold/Cough remedies
❑ Diarrhea Preparations
❑ Eye Drops
❑ Herbal Remedies
❑ Laxatives
❑ Pain Medicines
❑ Sleeping Medicine
❑ Vitamin/Supplements
❑ Recreational Drugs
❑ Weight Loss Medications
❑ 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

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

SURGICAL HISTORY:

LIST PREVIOUS SURGERIES/INJURIES/HOSPITALIZATIONS OR PROCEDURES (INCLUDE EYE SURGERIES) ❑**NONE**

DATE	PROCEDURES

OTHER:

Yes No

❑ ❑ Do you use tobacco?
❑ Cigarettes_____ packs/day ❑ Cigars ❑ Pipe ❑ Chew Quit when?_____ Years of use?_____

❑ ❑ Do you use alcohol? How Much?_____ Last drink_____

❑ ❑ Prosthetic Devices: ❑ Joint Replacements ❑ Lens Implants ❑ Right ❑ Left ❑ Other _____

PLEASE COMPLETE OTHER SIDE