EXCEL EYE CENTER

EXCEL COSMETIC SURGERY CENTER

Patient Name: _____ **Birth Date:** _____ **Date of Visit:** _____

Health History Questionnaire

Do you drive?	Yes/No	**Do you use tobacco products?**	Yes/No	Packs per day_____
Do you drink alcohol?	Yes/No	**Do you use recreational drugs?**	Yes/No	

List all <u>medications</u> you are currently taking (prescription or over the counter including eye drops):

_____

_____

List <u>allergies</u> to medications or other substances: _____

Health History (Please circle if you, or a blood relative, have ever had any of the following conditions)

Condition	**You**	**Family Member**	**Conditions**	**You**	**Family Member**
Aids/HIV	Yes	Yes_____			
Arthritis	Yes	Yes_____	Kidney Disease	Yes	Yes_____
Asthma	Yes	Yes_____	Lupus	Yes	Yes_____
Bleeding	Yes	Yes_____	Macular Degeneration	Yes	Yes_____
Blood Pressure	Yes	Yes_____	Pacemaker	Yes	Yes_____
Cancer (type)	Yes	Yes_____	Diabetes Type I or II	Yes	Yes_____
Rheumatic Fever	Yes	Yes_____	Emphysema	Yes	Yes_____
Shingles	Yes	Yes_____	Epilepsy	Yes	Yes_____
Skin Conditions	Yes	Yes_____	Glaucoma	Yes	Yes_____
Stroke	Yes	Yes_____	Hay Fever	Yes	Yes_____
STD(s)	Yes	Yes_____	Heart Condition	Yes	Yes_____
Thyroid Condition	Yes	Yes_____	Hepatitis (type)	Yes	Yes_____
Tuberculosis	Yes	Yes_____	Other: _____		

Review of Systems (Please circle to indicate if you have ever had any of the following problems)

Skin	Cardiovascular (heart/blood vessels)	Lymph Nodes (swelling)
Head	Gastrointestinal (stomach/intestines)	Blood
Ears/Nose/Mouth/Throat	Genitourinary (genitals/kidney/bladder)	Seasonal Allergies
Respiratory (lungs/Breathing)	Bones/Joint/Muscles	Mental Illness
Neurological		

Eye Health History (Please circle any of the conditions you are currently experiencing)

Red Eyes	Double Vision	Glaucoma	Seeing Halos	Blurred Vision
Dry Eyes	Headaches	Seeing Floaters	Burning Eyes	Eye Infection(s)
Itchy Eyes	Temporary Vision Loss	Cataracts	Eye Injury	Light Sensitivity
Twitching Eyelid(s)	Crossed/Lazy Eye(s)	Eye Strain	Loss of Vision	Poor Vision
Poor Color Vision	Fainting Spells/Dizziness	Migraine Headaches	Watering Eye(s)	

List all previous surgeries and date performed: _____

_____

Date of last eye exam: _____

Health history reviewed by: _____ **Date reviewed:** _____