## MidWest Eye Center Surge PATIENT HISTORY FORM

## Please Complete and Bring this Form the Day of Surgery Please fill out this form for <u>each</u> surgery done at the Surgery Center

<b>Date:</b> October 6, 2016							
Name: «PName»	DOI	<b>8:</b> <u>«PDOI</u>	B» Chart #: «PNumber»				
			of the following: (If multip	ole symptoms listed circl	e the one	es that ap	pply)
,	Y	N	Comments	7 1	Y	N	Comments
Asthma				Claustrophobia			
**Coughing/Night Sweats				· ·			
Fever/Bloody Mucus **Circle Symptom			Ulcers/Bleeding				
Emphysema				Hiatal Hernia			
Shortness of Breath				Kidney Problems			
Other Lung Problems				Urination Problems			
Smoker (how much)				Diabetes			
Heart Disease/Murmur				Low Blood Sugar			
Heart Attack(s) when				Thyroid Problems			
Irregular/fast Heartbeat				Convulsions/Epilepsy			
Chest Pain/Angina High Blood Pressure				Stroke/Paralysis Easily Nauseated			
Low Blood Pressure				Hearing Problems			
Jaundice/Hepatitis				Contact Lenses			
Liver Trouble/Alcohol				Dentures			
Arthritis				Glaucoma			
Back Pain/Injury				Other Conditions			
Problems lying on back/				Previous Anesthesia/			
Breathing				Types/Problems:			
Anemia				Previous Surgery/			
Sickle Cell Disease				History of MRSA			
Bleeding Disorders				Family History:			
Blood Clot/When/Where				Heart/Lungs/Stroke			
				Seizures			
				Height: W	eight:	S	Sex: M F
				Vaccinations: Circle: Y	or N Pi	neumoco	ccal: Y N Influenza Y N
				Home Infestations: Ci	rcle: Re	ed Ruose	Parasites:
				Home Infestations: Ci		ed Bugs:	
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