PATIENT HISTORY

MIDWEST EYE CENTER

TO BE COMPLETED BY THE PATIENT
BRING NEWLY COMPLETED FORM TO EACH SURGICAL PROCEDURE

☐ **FIRST EYE** ☐ **SECOND EYE**

NAME _____ **DOB** _____

PATIENT ID # _____ **AGE** _____ **SEX** _____ **HEIGHT** _____ **WEIGHT** _____

PRIMARY CARE PHYSICIAN _____ **PHYSICIAN OFFICE #** _____

YES	NO	**PULMONARY**
		Asthma
		COPD / Emphysema
		Current Smoker Packs a day _____
		Obstructive Sleep Apnea (CPAP / BIPAP)
		Chronic Cough
		History of TB Infection
		Current or Recent Respiratory Infection
		Home Oxygen Use # of Liters _____
YES	NO	**CARDIAC**
		High Blood Pressure
		High Cholesterol
		Shortness of Breath
		Heart Disease
		Heart Attack: Date _____ Stents Placed _____ Bypass Surgery _____
		Chest Pain / Angina
		Congestive Heart Failure or Cardiomyopathy
		Heart Valve Problems / Murmur Mitral Prolapse _____ Valve Replacement _____
		Irregular Heart Beat: AFIB _____ If other, please specify _____
		Blood Clots (Lungs, Legs)
		On Blood Thinners?
		Pacemaker / Defibrillator Implant
		Abdominal or Thoracic Aneurysm
YES	NO	**HEPATIC**
		Liver Problems
		Hepatitis (A / B / C)
		Alcohol How Much Per Week _____

YES	NO	**DEVICES**
		Dentures
		Hearing Aids / Hard of Hearing
		Glasses / Contacts
		Cane / Walker / Wheelchair
YES	NO	**HOME INFESTATIONS**
		Bed Bugs
		Lice / Fleas / Other
YES	NO	**ANESTHESIA PROBLEMS**
		Nausea / Vomiting / Motion Sickness
		Difficult Airway
		Slow to Wake Up
YES	NO	**PSYCH**
		Anxiety
		Depression
		Bipolar
		Schizophrenia
		Claustrophobia
		Substance Abuse / Drug Disorder Specify_____
YES	NO	**NEURO / MUSCULAR / VASCULAR**
		Peripheral Vascular Disease (Bad Circulation)
		Stroke / TIA
		Multiple Sclerosis
		Myasthenia Gravis
		Parkinson's
		Dementia / Alzheimer's
		Fibromyalgia
		Tumors / Brain Aneurysms
		Seizures: Type last time? _____
		Arthritis Location_____
		Cervical Thoracic or Lumbar Disc Pain / Limited Motion
		Anemia
		Sickle Cell / Bleeding Disorder

YES	NO	**ENDOCRINE**
		Diabetes (Type I or Type II)
		Thyroid (Hypo / Hyper)
		Long-term steroid use
		Other
YES	NO	**RENAL / GU**
		Kidney Disease
		Dialysis Last Date _____
		Enlarged Prostate
		Urinary Problems
YES	NO	**GASTROINTESTINAL**
		GERD / Ulcers
		Hiatal Hernia
		Gastric Bypass / Sleeve
		Bowel Problems / IBS / UC / Crohn's
		Frequent Nausea
YES	NO	**OTHER**
		Cancer Type:_____
		Circle: (Radiation / Chemo / Surgery)
		HIV / AIDS
		Other Medical Conditions (describe) _____

MEDICATION ALLERGIES & REACTIONS

_____
_____
_____
_____

I have answered these questions to the best of my ability

_____
PATIENT SIGNATURE

_____
DATE

DO NOT WRITE BELOW THIS LINE ----------FOR ANESTHESIA PERSONNEL ONLY----------

Mental Status: This patient appears to be mentally competent.

Yes_____ **No**_____

Physical Examination: (See Anesthesia Record)
Heart
Lungs
Other

This patient _____**IS** _____**IS NOT** medically cleared to undergo the planned surgery utilizing monitored anesthesia care and sedation with an ambulatory surgery center as an acceptable setting.

Surgeon's Signature _____ Date _____ Anesthesia Provider Signature _____ Date _____