

PATIENT HISTORY

Date _____

Name _____

Referred By _____

Occupation When Working _____

Age _____

1. What is the reason for your visit today? _____

2. Do you have, or have you ever had or been treated for, any of the following:

	YES	NO		YES	NO		YES	NO
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding (Abnormal)	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	G I Disease	<input type="checkbox"/>	<input type="checkbox"/>	Eyelid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Eye Muscle Problems	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>

3. What medicines do you take regularly? Include eye drops and ointments, vitamins and over-the-counter medicines.

4. Have you had any cosmetic surgeries, treatments or procedures? Please include approximate dates.

5. What operations have you had? Please include approximate dates.

6. Are you allergic to any medicine? Please list.

7. What is the name and **PHONE** number of your family physician?

8. Approximately when was your last medical checkup?

**The Center For &
Cosmetic Facial
Eye Plastic Surgery**

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