FORM REQUIRED BY YOUR PROVIDER

PLEASE PRINT

Office Use Only: S / V / N / C
EHR Entered Date: _____
SESC: _____

NAME _____ BIRTHDATE _____ TODAY'S DATE _____

Nickname: _____

Primary Care Provider and Facility: _____

Name of Referring Provider and Facility: _____

Preferred Language: ○ English ○ Other_____

Gender: ○ Male ○ Female ○ _____

Race: _____

Ethnicity: ○ Hispanic or Latino
○ Not Hispanic or Latino
○ Unknown/Not Reported

***If you do not know your current medications and allergies (including reactions), you must contact your primary care provider before day of surgery.**

Medication Allergies (Please indicate reaction): ○ No Known Allergies

Are you allergic to any of the following? ○ Tape ○ Latex ○ Povidone-iodine (Betadine)

Current Ocular Medications

Name	Dosage	Frequency

Current Medication List (Please include any Vitamins, Supplements and/or OTC medications)

I give my consent to access my medication history electronically. Please initial: _____Yes _____No

Name	Dosage	Frequency

***** If you take more than 10 prescribed medications, please attach a list *****

Past Medical History: Please mark all that apply (even if history of -or- currently on treatment for)

HEENT:
- Dentures/Partials (Upper, Lower, or both)
- Hearing Loss (Hearing Aids: Yes____ No ____)
- Chronic Sinus Drainage

_____
_____
_____

Cardiovascular:
- High Blood Pressure
- Congestive Heart Failure
- Irregular heartbeat
- Heart Attack
- Chest Pain
- Palpitations
- Pacemaker/Defibrillator
- Exercise Intolerance

_____
_____
_____

Name of Cardiologist and Facility:

_____

Genitourinary:
- Kidney Disease
- Dialysis
- Have you ever been prescribed an Alpha 1 Blocker/Prostate medication
  - Examples: Tamsulosin, Flomax, Doxazosin, Prazosin, Terazosin

_____
_____
_____

Musculoskeletal:
- Difficulty/pain lying flat on your back
- Arthritis
- Scoliosis
- Joint Pain or Stiffness
- Back Pain
- Neck Pain
- History of Falling within last 12 Months
- Unsteady when Standing or Walking
- Do you feel that you are at high risk to fall

_____
_____

Gastrointestinal:
- Acid Reflux/Heartburn/Indigestion
- Hiatal Hernia

_____
_____
_____

Pulmonary:
- Asthma
- COPD
- Persistent Cough
- Shortness of Breath
- Oxygen Dependent (Flow Rate: _____)
- Sleep Apnea - Treatment: _____
- Difficulty Breathing While Lying Flat

_____
_____
_____

Neuropsychiatric:
- Stroke
- TIA
- Seizure Disorder
- Neuropathy
- Narcolepsy
- Restless Leg Syndrome
- Memory Difficulties
- Anxiety
- Claustrophobia
- Balance Issues
- Tremors
- History of head trauma with loss of consciousness

_____
_____
_____

Metabolic/Endocrine:
- Diabetes (Type 1 or Type 2)
- Thyroid Disease (Over-Active or Under-Active)

_____
_____

Other Medical History not listed above:
- Cancer
- Autoimmune Diseases
- History of chronic steroid use

_____
_____

Patient Name: _____ **Birthdate:** _____

Past Ocular History: (Please indicate which eye *and* date if known)

- ○ Cataract _____
- ○ Strabismus (lazy eye) _____
- ○ Retinal Detachment _____
- ○ Eye Trauma _____
- ○ Glaucoma _____
- ○ Macular Degeneration_____
- ○ Refractive Surgery (LASIK/PRK)_____
- ○ Other _____

Past Surgical History: (Please indicate date if known)

- ○ None
- ○ Prior Eye Surgeries _____
- _____
- _____
- ○ Tonsillectomy/Adenoidectomy _____
- ○ Thyroidectomy_____
- ○ Coronary Artery Bypass _____
- ○ Cardiac Stents _____
- ○ Pacemaker/Defibrillator _____
- ○ Heart Valve _____
- ○ Bariatric Surgery _____
- ○ Hysterectomy _____
- ○ Hernia _____
- ○ Spinal Surgery _____
- ○ Orthopedic/Joints _____
- ○ Other:_____
- _____
- _____
- _____
- _____

Family History (Mark those that apply and indicate relation)

	Relation		Relation		Relation
○ Lazy eye	_____	○ Macular Degeneration	_____	○ Blindness	_____
○ Glaucoma	_____	○ Cancer	_____	○ Heart Disease	_____
○ Autoimmune Disease	_____	○ Diabetes	_____		

Social History

Current Smoking Status:

Have you ever used tobacco?	**No**	**Yes**
Every day	○	○
Occasionally	○	○
Previously	○	○

	No	**Yes**	Previous	Amount	How Often?
Alcohol?	○	○	○	_____	_____

Recreational Drug Use: ○ **No** ○ **Yes** (If Yes, please explain below)

_____

_____

_____

Vaccinations:

	No	**Yes**	
Influenza	○	○	Date:_____
Pneumonia	○	○	

For Patients 65 and Older :

	No	**Yes**	**#Falls**
Falls in the last year:	○	○	_____
Did fall result in injury?	○	○	Date: _____

Details: _____

_____

Immunizations: (N/A if patient is 18 yr or older)

If under 18, are immunizations current?

- ○ Yes
- ○ No - **Patient counseled to follow up with PCP Initials:** _____

Patient Signature: _____ **Date:** _____

***For SESC use only**:*

CRNA Signature/Initials _____ **Date:** _____

CRNA Signature/Initials _____ **Date:** _____

CRNA Signature/Initials _____ **Date:** _____