Oculoplastic Consultants of Central PA
Patient History Form

PLEASE FILL OUT COMPLETELY & USE BLUE OR BLACK PEN

Name_____ **Date**_____

Please list current medications:

Name of Medication	Reason for Taking	Dosage	How Often

Do you take aspirin, ibuprofen (Advil, Nuprin), Dipyrimadole? Yes□ No□ **Coumadin?** Yes□ No□

Do you take prophylactic antibiotics prior to dental work? Yes□ No□

If yes, please list prescribed medication and dosage_____

Pharmacy name and number: _____

Allergies to Medications	Surgical History	Medical History

Circle if you have: Pacemaker or Defibrillator (provide implant device ID card)

Review of Systems

GENERAL
□good health
□weight change
□diabetes
□thyroid disease

EAR/NOSE/THROAT
□sinus disease
□nose bleeds
□deviated septum
□recent loss of hearing
□difficulty swallowing

CARDIOVASCULAR
□high blood pressure
□artificial heart valve
□heart disease
□rheumatic fever

RESPIRATORY
□shortness of breath
□wheezing
□cough

GASTROINTESTINAL
□nausea
□heartburn
□hiatal hernia

GENITOURINARY
□frequent urination
□blood in urine

SKIN
□cold sores
□recent changes in hair or nails
□skin lesions
□skin cancer
□MRSA

MUSCULOSKELETAL
□joint pain, stiffness
□muscle weakness
□artificial joint

NEUROLOGICAL
□headaches
□paralysis
□seizures

PSYCHIATRIC
□depression
□memory loss

BLOOD
□bleeding or bruising
□anemia
□HIV (optional)

SOCIAL HISTORY

Smoking: □No □Yes _____packs per day

Alcohol: □No □Yes _____number of drinks per □day □week □month