Texas Eye Surgery Center

Medical History

Patients Name: _____ **Height:**____ **Weight:**_____

Birthdate: MM DD YYYY

Date of surgery: MM DD YYYY

Please check all that apply:

☐Smoker / Tobacco	☐Stomach issues	☐Diabetic: Oral/Diet/Insulin
☐Alcohol use	☐Hepatitis	☐Unusual bleeding
☐Tuberculosis	☐Renal Disease	☐Problems with anesthesia
☐Asthma/COPD	☐Dialysis	☐Stroke/date: MM DD YYYY
☐Oxygen___liters/min	☐Prostate issues	☐Seizures
☐MRSA/VRE	☐Arthritis	☐Depression/Anxiety
☐Thyroid	☐High blood pressure	☐High cholesterol
☐**HEART ATTACK** ***	☐Chest pain	☐Shortness of breath
Date: MM DD YYYY	☐ Irregular Heart Rate	☐Pacemaker
☐Hard of Hearing	☐Dentures	☐Internal defibrillator
☐Hearing Aide	☐Sleep apnea/bipap	
☐IV port	☐Language barrier_____	

☐Other:_____

_____

List your allergies including what reaction you have to each listed: (latex, tape, Iodine/ Betadine, eggs)

_____

_____

_____

Check if you ever taken: ☐ Flomax ☐ Cardura ☐ Any other medication for your prostate

List of previous surgeries:

_____

_____

_____

***IF YOU HAVE HAD A HEART ATTACK WITHIN THE LAST 6 MONTHS, YOU MUST PROVIDE US WITH A MEDICAL CLEARANCE FOR SURGERY FORM FROM YOUR CARDIOLOGIST PRIOR TO HAVING SURGERY

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MEDICATION LIST

List of your current medications – herbal treatments – eye drops – Over-the-counter medications

Patient name: _____

Date of birth: _____

Date of surgery: _____

Medication Name and Route (how you take it - by mouth, injection, topical, patch)	Dose	How Often	Why do you take it?

You may submit your form via email by clicking the button to the right. When prompted please choose how you would like to email to us. If you cannot email this form. Please print it and bring it with you.

Send in Email