The Center for Eye and Facial Plastic Surgery

Patient History

Name:_____ Sex: □ M □ F Date:_____

Social Security #: _____ Age: _____ Date of Birth: _____

Marital Status (circle) M S D W Spouse's Name_____

Guardian's Name (if patient under 21) _____

Mailing Address_____

Home Telephone ( )_____ Work telephone ( )_____
Email Address_____ Cell phone ( )_____
Occupation_____ Employer_____
May we leave a message on your home phone? Yes____ No____
May we leave a message on your cell phone? Yes ____ No ____
Emergency Contact_____
Emergency Phone #_____Pharmacy #_____

Insurance Information of Responsible Party:

Insurance Company_____ Insurance Company_____
Policy/Group #_____ Policy/Group #_____
Insured Party_____ Insured Party_____
Insured Party's Date of Birth_____ Insured Party's Date of Birth_____
Insured Party's Social Security #_____ Insured Party's Social Security #_____
Referring Physician's Name_____
Physician's Address_____
_____

DO YOU WANT YOUR REFERRING DR TO RECEIVE A REPORT: YES_____ NO_____
Names and Addresses of physicians and any other individuals who should be made aware of this consultation with a report:

_____
_____
_____
_____
_____

The undersigned authorizes the payment of all available surgical and medical benefits directly to the physician. In accordance with the terms of this office's *Notice of Privacy Practices*, the undersigned authorizes the physician to obtain any and all information acquired in the course of the examination or treatment of the patient and to release any and all such information for the purpose of obtaining payment.

The undersigned consents to photographing the patient and appropriated portions of the patient's body and to the modification, use, display, and publication of such photographs for medical, scientific or educational purposes provided that the patient is not identified by name in accordance with the terms of this office's *Notice of Privacy Practices*.

_____ _____
Patient (or Parent if minor) Insured (or Authorized Person)

Patient Information-please answer all of the following questions. Name_____

1. Are you being treated or have you ever been treated for any the following?

skin cancer	□ no	□ yes
diabetes	□ no	□ yes
arthritis	□ no	□ yes
high blood pressure	□ no	□ yes
heart disease	□ no	□ yes
stroke	□ no	□ yes
other cancer	□ no	□ yes
thyroid problems	□ no	□ yes
autoimmune problems (lupus, AIDS)	□ no	□ yes
infectious diseases (hepatitis, herpes)	□ no	□ yes

other known medical conditions: _____

2. Have you had any immunizations in the last 3 weeks or planning any immunizations in the next 3 weeks? □ no □ yes Date: _____

3. Have you had surgery in the past? □ no □ yes
If yes, please list date and operation:_____
_____

4. Have you had cataract surgery? □ no □ yes Which eyes? □ left □ right
Do you have intraocular lenses? □ no □ yes Which eyes? □ left □ right
Please list surgery dates and treating physician's name: _____

5. Have you had Lasik Surgery? □ no □ yes Please list surgery date and treating physician: _____

6. Have you had any dental work in the past 2 weeks or planning to have dental work in the next 2 weeks? □ no □ yes Date: _____

7. Have you been hospitalized in the past? (other than for surgery) □ no □ yes
If yes, please list date(s) and reason(s):_____
_____
_____
_____

8. Please list all prescription medicines that you are now taking:

_____ _____
_____ _____
_____ _____
_____ _____

9. Please list over the counter medications, vitamins, and health food supplements you are now taking:

_____ _____
_____ _____
_____ _____

10. Please list all eye drops or ointments you are now taking:

_____ _____

_____ _____

11. Are you taking any of the following medications/herbals? □Yes □No

(Please circle what you are taking)

Coumadin Plavix Aspirin Baby aspirin Ecotrin Motrin Ibuprofen Advil

Naprosyn Aleve Anaprox Celebrex Vioxx Vitamin E Other blood thinners

Gingko Garlic pills Ginger Ginseng Fish Oil Omega 3 Fatty Acids

12. Do you smoke? □ no □ yes Packs per day? _____ How long?_____yrs

13. Do you drink alcohol? □ no □ yes how much? _____

14. Are you allergic to any drugs or have you had drug reactions? □ no □ yes

15. Do you have pets? □Yes □No If yes, do you sleep with your pets? □Yes □No

PLEASE LIST ALL DRUGS THAT YOU ARE ALLERGIC TO: _____

_____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS?

Unexplained weight loss, fatigue, weakness	□ no	□yes_____
Skin rashes or sore	□ no	□yes_____
Headache	□ no	□yes_____
Hearing loss or ringing in the ears	□ no	□yes_____
Sinus trouble or nose bleeding	□ no	□yes_____
Chest pain or irregular heartbeat	□ no	□yes_____
Shortness of breath or cough	□ no	□yes_____
Heartburn, stomach pain, vomiting	□ no	□yes_____
Wheezing or asthma	□ no	□yes_____
Diarrhea, blood in stools	□ no	□yes_____
Pain on urination, blood in urine	□ no	□yes_____
Muscle aches, joint pain, swollen joints	□ no	□yes_____
Numbness or tingling, dizziness, fainting, blackouts	□ no	□yes_____
Muscle weakness or paralysis	□ no	□yes_____
Memory loss or confusion	□ no	□yes_____
Depression or mood changes	□ no	□yes_____
Excessive urination or thirst	□ no	□yes_____
Bruising, bleeding, or anemia	□ no	□yes_____
Sleep Apnea	□ no	□yes_____
Other	□ no	□yes_____

Your appointment time is very important to us. Should you need to reschedule your appointment, please know that we appreciate as much notice as possible, with a minimum of 48 hours whenever possible. If you cancel your appointment with Dr. Ramesh for a cosmetic consult without giving 48 hours' notice, we will be unable to refund your $150.00 deposit. Thank you, and we look forward to seeing you soon!

Name: _____