Coastal Eye Medical History Form

1. Patient Information **Date:_____**

Full Name _____

Date of Birth _____ **Dentures** □ **Yes** □ **No**

Age _____ **Glasses** □ **Yes** □ **No**

Gender ☐ **Male** ☐ **Female** ☐ **Other**

Height & Weight _____

Contact Number _____

Preferred Pharmacy _____

2. Allergies ☐ **No Known Allergies (NKA)**

3. Medications: (We can make a copy of your list and attach if needed.) ☐ **No Meds**

4. Surgical History:

Previous anesthesia complications: if yes please explain ☐ Yes ☐ No

Family history of anesthesia issues (e.g., malignant hyperthermia): ☐ Yes ☐ No

Surgery List (Year if known)

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Conditions	***Yes / No***	***Details / Comments***
Asthma / COPD	**☐ Yes ☐ No**	
Use Oxygen?_____Liters		
Sleep Apnea (CPAP use?)	**☐ Yes ☐ No**	
Heart disease (e.g., heart attack, failure)	**☐ Yes ☐ No**	
Congestive heart failure ☐ Yes ☐ No		
Heart Surgery/Stents ☐ Yes ☐ No		
Palpitations/irregular heart beat ☐ Yes ☐ No		
Heart attack w/in last 6month? ☐ Yes ☐ No		
Pacemaker/Defibrillator? ☐ Yes ☐ No		
If yes, placed when?_____		
High Cholesterol? ☐ Yes ☐ No		
Any History of Angina/Chest pain? ☐ Yes ☐ No		
Stroke or TIA	**☐ Yes ☐ No**	
w/in last 6 months? ☐ Yes ☐ No		
Seizures / Epilepsy	**☐ Yes ☐ No**	
Bleeding/clotting disorders	**☐ Yes ☐ No**	
Depression/Anxiety/ claustrophobia	**☐ Yes ☐ No**	
Kidney disease	**☐ Yes ☐ No**	
Liver disease	**☐ Yes ☐ No**	
Acid reflux / GERD	**☐ Yes ☐ No**	
Tobacco use or Marijuana	**☐ Yes ☐ No**	Type/Frequency:
Alcohol use	**☐ Yes ☐ No**	Amount/Frequency:
Diabetes	**☐ Yes ☐ No**	
☐ *Type 1* ☐ Type 2 Recent A1C_____		
Thyroid Disease	**☐ Yes ☐ No**	
Dialysis	**☐ Yes ☐ No**	
Hospitalized in the past 6 months	**☐ Yes ☐ No**	

Family Physician:_____ Phone #_____

Specialists:_____ Phone #_____