Patient Medical History

Advanced Artificial Eyes

18455 Burbank Blvd. Suite 202, Tarzana CA 91356

Last Name _____ First Name _____ Middle Name _____ Birth Date _____

Health problems that you may have, or medication that you may be taking, could have an important relationship with the care you will receive. Thank you for answering the following questions:

Which eye did you damage? ◯ Left ◯ Right

When did you damage your eye? _____

How did you damage your eye? _____

What surgeries have you had? _____

When did you have your surgeries? _____

What problems do you currently have with your eye? _____

What problems do you have with your current prosthesis? _____

What would you like to improve with your current prosthesis? _____

How frequently do you remove your prosthesis? _____

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications. pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Fen-Phen or Redux? ◯ Yes ◯ No If yes, please explain: _____

Have you ever tal\en Flomax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women, are you:
- ☐ Pregnant or trying to get pregnant?
- ☐ Taking oral contraceptives?
- ☐ Nursing?

Are you allergic to any of the followlng?

☐ Aspirin ☐ Penicilin ☐ Codeine ☐ Acrylic ☐ Silicone ☐ Latex ☐ Local Anesthetics ☐ Iodine ☐ Sulfa ☐ Drugs

If yes, please explain: _____

Do you have, or have you had, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimers Disease
- ☐ Anaphylalls
- ☐ Anemia
- ☐ Anigma
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Diarrhea
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Binda
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Yellow Jaundice

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform this office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____