LIVONIA OPHTHALMOLOGISTS, P.C.

NAME: _____ DATE _____

ARE YOU CURRENTLY HAVING:

	YES	NO		YES	NO
Allergy to adhesive			Dry mouth		
Allergy to lidocaine			A cold		
Blood thinners			Cough		
Defibrillator			Diarrhea		
Flomax			Constipation		
Pacemaker			Burning on urination		
Pregnancy or planning pregnancy			Joint pain		
Eye pain			Lower back pain		
Tearing			Arthritis		
Red eyes			Rash		
Scalp tenderness			Headache		
Recent change in vision			Stroke		
High blood pressure			Anxiety		
Diabetes			Depression		
High or low thyroid			Bleeding / easy bruising		
Fever			Anemia		
Weight loss			Allergies		
Runny nose			Hay fever		
Sinus congestion			Hives		

Circle any you have been diagnosed with:

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Enlarged Prostate
COPD/Emphysema
Heart Disease
Depression
Diabetes
Kidney Failure
Reflux
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
High Thyroid
Low Thyroid
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Stroke
Other _____

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Circle any surgeries you have had:

Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Coronary Artery Bypass
Prostate Removed: Prostate Cancer
TURP
Basal Cell Cancer Surgery
Squamous Cell Cancer Surgery
Melanoma Surgery
Other _____

Eye History Circle any you have been diagnosed with:

Blepharitis
Cataract (Right Eye, Left Eye)
Diabetic Retinopathy
Dry Eyes
Glaucoma (Right Eye, Left Eye)
Other _____
Macular Degeneration (Right Eye, Left Eye)
Ophthalmic Migraine
Retinal Tear (Right Eye, Left Eye)
Crossed Eyes
Vitreous Floaters (Right Eye, Left Eye)

Circle any eye surgeries you have had:

Blepharoplasty (Right Eye, Left Eye)
Cataract Surgery (Right Eye, Left Eye)
Corneal Transplant (Right Eye, Left Eye)
Eye Muscle Surgery
Intravitreal Injections (Right Eye, Left Eye)
Other _____
LASIK (Right Eye, Left Eye)
PRK (Right Eye, Left Eye)
Ptosis Repair (Right Eye, Left Eye)
Punctal Plugs (Right Eye, Left Eye)
Glaucoma Surgery (Right Eye, Left Eye)

Family History circle all that apply:

Blindness
Cancer
Cataracts
Other _____
Diabetes
Glaucoma
Macular Degeneration
Migraine
Retinal Detachment
Crossed Eyes

Cigarette Smoking:

_____ Never smoked
_____ Quit: former smoker
_____ Smokes less than daily
_____ Smokes daily

Vaccines:

_____ Pneumonia Vaccination
_____ Shingrix Vaccination (Shingles vaccine 2 doses)

Advanced Care

Do you have a health care proxy in the event you are unable to make your own medical decisions? _____

Do you have a living will? _____

Which statement(s) best reflects your wishes on advanced care recommendations?

_____ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

_____ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.

_____ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

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Please list all medications you are taking. Include prescriptions, over-the-counter and vitamins.

MEDICATION	DOSE	FREQUENCY

DRUG ALLERGIES: