

EYELID SURGERY, DEAN W. LARSON, M.D.
PATIENT INFORMATION SHEET

Date_____

Name_____Social Security#_____

Sex_____Birthdate_____Age_____

Local Address_____

City_____State_____Zip Code_____

Home Phone_____Work Phone_____

Work Address_____Cell #_____

Northern Address_____

City_____State_____Zip Code_____

Northern Phone_____

Marital Status_____Spouse_____

Whom May We Thank For Referring You?_____

Authorization:

I authorize that payment of Medicare or other insurance benefits be made either to me or on my behalf to Dean W. Larson, M.D. for any services furnished to me by that physician. I authorize any holder of medical information about me to release to an insurance company or the Health Care Financing Administration and its agents any information needed to determine these benefits. In Medicare assigned cases, Dean W. Larson, M.D. agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services.

Signature

Date

EYELID SURGERY
PATIENT MEDICAL HISTORY FORM

Patient Name _____ Referred by _____

Date of Birth _____ Age _____

PAST MEDICAL HISTORY

(Please list, including **dates**, any **surgery, operations, or hospitalizations** other than eyes)
(Please: include ALL **General Medical Problems**)

PAST OCULAR HISTORY

(Please list, including **dates**, any **surgery** on your **eyes** (Cataract); or **eyelid area**, including skin cancer?)
(Please include **ANY EYE MEDICAL PROBLEMS** in the past)

Please circle any of the following that you have: Cataracts, Glaucoma, or Retinal Disease. Or circle: **No**

ALLERGIES: are you allergic to any medication? Please circle Y N. If yes, please list & reaction.

Do you have any sinus nasal allergies, including hay fever, sinusitis, or rhinitis? Y or N

MEDICATIONS: Please list all medications, vitamins, & herbal supplements that you are currently taking.

MEDICATION NAME	STRENGTH	TIMES TAKEN PER DAY

Please continue on back if you need more room.

Are you taking, or have you taken an **ASPIRIN**, even a baby aspirin, within the last month? Y or N _____

Do you take **ANY** medication for **ARTHRITIS** or joint pain, including Motrin, ibuprofen, naprosyn, voltaren, indomethocin, bufferin, Excedrin, ecotrin, ascription, feldene, coumadin, persantene or any other **blood thinning medication**? Y or N If yes please explain. _____

Have you had a joint replacement or have any artificial parts in your body? Y N

Do you require antibiotics prior to surgery or dental work? Y or N If yes, please explain. _____

Who is your **PRIMARY MEDICAL PHYSICIAN**? _____ phone # _____

Who is your **EYE DOCTOR**? _____ phone # _____

Signature _____ Date _____

Reviewed by DWL _____

REVIEW OF SYTEMS*In addition to your past medical history; do you currently have any of the following?**If YES please explain!*

1. Constitutional (fever, weight loss, chronic fatigue)	<input type="checkbox"/> yes <input type="checkbox"/> no	
2. Eyes (glaucoma, cataract, lazy eye, retinal problems)	<input type="checkbox"/> yes <input type="checkbox"/> no	
3. Ear/nose/mouth/throat (hearing loss, sinus problems, sore throat)	<input type="checkbox"/> yes <input type="checkbox"/> no	
4. Cardiovascular (heart problems, chest pain, irregular heart beat, heart attack, High Blood Pressure?)	<input type="checkbox"/> yes <input type="checkbox"/> no	
5. Respiratory (asthma, shortness breath, tuberculosis, coughing)	<input type="checkbox"/> yes <input type="checkbox"/> no	
6. Gastrointestinal (heartburn, stomach pain, diarrhea, vomiting, ulcers, colitis, Hepatitis?)	<input type="checkbox"/> yes <input type="checkbox"/> no	
7. Genitourinary (urinary problems, pain, blood in urine)	<input type="checkbox"/> yes <input type="checkbox"/> no	
8. Integumentary (skin) (skin rashes, excessive scarring, keloids?)	<input type="checkbox"/> yes <input type="checkbox"/> no	
9. Musculoskeletal (muscle aches, joint pain, Joint Replacement?)	<input type="checkbox"/> yes <input type="checkbox"/> no	
10. Neurological (numbness, stroke, headaches, paralysis)	<input type="checkbox"/> yes <input type="checkbox"/> no	
11. Hematological/Lymphatic (blood disorder, leukemia, anemia (Blood Transfusion? Bruise/Bleed Easily?))	<input type="checkbox"/> yes <input type="checkbox"/> no	
12. Allergic/Immunologic (hay fever, allergies, AIDS, HIV Sinusitis?)	<input type="checkbox"/> yes <input type="checkbox"/> no	
13. Endocrine (thyroid problems, dry hair, Diabetes?)	<input type="checkbox"/> yes <input type="checkbox"/> no	
14. Psychiatric (depression, anxiety)	<input type="checkbox"/> yes <input type="checkbox"/> no	
15. Cancer of any type (prostate, lung, breast, Skin Cancer?)	<input type="checkbox"/> yes <input type="checkbox"/> no	

FAMILY HISTORY: Do any of the following run in your family? (Please circle Y (Yes) N (No))

Y N Cancer Y N Diabetes Y N High Blood Pressure Y N Heart Disease
 Y N French-Canadian Descent Y N Irish-Welch-English-Scand Y N Skin Cancer
 Y N Droopy Lids Y N Congenital Ptosis Y N Glaucoma Y N Macular Degeneration

SOCIAL HISTORY: Smoking Y / N how much? _____ Alcohol Y / N daily, weekly? _____
 Have you had a lot of sun exposure? Y / N Do you live alone? Y / N

Signature _____ Date _____

Reviewed by DWL _____