TEXAS OPHTHALMIC PLASTIC, RECONSTRUCTIVE & ORBITAL SURGERY ASSOCIATES

TODAY'S DATE ________________ PHYSICIAN: ☐ GILLILAND ☐ VRCEK ☐ HARRINGTON

PATIENT INFORMATION

FULL NAME: LAST	FIRST	MIDDLE	
ADDRESS	CITY	STATE	ZIP
HOME PHONE #	WORK	CELL	
EMAIL ADDRESS	SSN	DRIVERS LICENSE #	
DOB	AGE	SEX	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED
EMERGENCY CONTACT (NOT LIVING AT SAME ADDRESS)	EMERGENCY CONTACT PHONE #		
EMERGENCY CONTACT RELATIONSHIP	WORK RELATED (YES OR NO)	ACCIDENT RELATED (YES OR NO)	
PHARMACY NAME	PHARMACY #	PHARMACY ZIP	

EMPLOYMENT

OCCUPATION	EMPLOYER		PHONE	
ADDRESS	CITY	STATE	ZIP	CONTACT

REFERRAL/RESPONSIBLE PARTY

GUARANTOR NAME: LAST	FIRST	MIDDLE	MAIDEN	
ADDRESS	CITY	STATE	ZIP	
HOME PHONE #	WORK	CELL		
SSN	DOB	AGE	SEX	DRIVERS LICENSE #
EMPLOYER	EMPLOYER ADDRESSS			
RELATION TO PATIENT	REFERRING DOCTOR NAME/ADDRESS			
PRIMARY CARE PHYSICIAN NAME/ADDRESS				

INSURANCE INFORMATION

NAME PRIMARY INSURANCE				NAME SECONDARY INSURANCE			
INSURANCE PHONE #				INSURANCE PHONE #			
ADDRESS				ADDRESS			
CITY	STATE	ZIP		CITY	STATE	ZIP	
POLICY #	GROUP #			POLICY #	GROUP #		
POLICY HOLDER (IF OTHER THAN PT)	DOB			POLICY HOLDER (IF OTHER THAN PT)	DOB		
SSN	RELATION TO PT			SSN	RELATION TO PT		
POLICY HOLDER'S EMPLOYER	WORK PHONE			POLICY HOLDER'S EMPLOYER	WORK PHONE		
EMPLOYER ADDRESS	CITY	STATE	ZIP	EMPLOYERS ADDRESS	CITY	STATE	ZIP

PATIENT HISTORY RECORD

PATIENT NAME ____ **DATE** __________________

AGE ____________________ **REFERRED BY** ___________________________________

PRESENT ILLNESS HEIGHT ________ WEIGHT __________

1. WHAT IS THE NATURE OF YOUR PROBLEM? ____
   ____
   ____
2. HOW LONG HAS THIS BOTHERED YOU (DAYS,WEEKS,MONTHS,YEARS) ______________________
3. DOES THE PROBLEM AFFECT YOUR VISION? YES ____ / NO ____
4. IS YOUR PROBLEM RELATED TO AN INJURY? YES ____ / NO ____
5. HOW SEVERE IS YOUR PROBLEM? MILD___ / MODERATE ___ / SEVERE___
6. IS THE PROBLEM RELATED TO AN INJURY? YES ___ / NO ____

PAST MEDICAL HISTORY

1. PLEASE LIST ALL MEDICAL PROBLEMS (DIABETES, HIGH BLOOD PRESSURE ETC.) _____________
   ____
   ____
   ____
   ____
2. PLEASE LIST **ALL** PREVIOUS SURGERIES.____
   ____
   ____
   ____

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1. DO YOU TAKE BLOOD THINNERS (INCLUDING ASPIRIN)? YES ____ / NO ____
2. HAVE YOU EVER WORN CONTACT LENSES? YES ____ / NO ____
3. DO YOU HAVE A HISTORY OF THYROID DISEASE? YES ____ / NO ____

ALLERGIES

LIST ALL MEDICATION ALLERGIES

MEDICATIONS

LIST **ALL** MEDICATIONS	DOSE (mg)	# PILLS	TIMES TAKEN PER DAY	DATE MEDICATION STOPPED

LIST ALL MEDICATIONS	DOSE	# PILLS	TIMES TAKEN/DAY	DATE STOPPED

SOCIAL HISTORY

1. DO YOU SMOKE? YES ____ / NO ____
2. ARE YOU PREGNANT? YES ____ / NO ____ / N/A ____
3. DO YOU DRINK ALCOHOL? YES ____ / NO ____
4. HAVE YOU HAD A FLU SHOT THIS YEAR? YES ____ / NO ____
5. HAVE YOU HAD A PNEUMOCOCCAL VACCINE? YES ____ / NO ____
6. DO YOU HAVE AN ADVANCED CARE PLAN / NAMED SURROGATE? YES ____ / NO ____

REVIEW OF SYSTEMS

EYES	Visual Loss (one or both eyes)	___Yes	___No
	"Dry Eyes"	___Yes	___No
	Double vision	___Yes	___No
	Thyroid eye disease	___Yes	___No
	Previous eye injury	___Yes	___No
	Wear glasses/contact lenses	___Yes	___No
	Previous eye or eyelid surgery	___Yes	___No
NOSE	Difficulty breathing through nose	___Yes	___No
	Sinus conditions	___Yes	___No
	Previous nasal/sinus surgery	___Yes	___No
	Irradiation to face or neck	___Yes	___No
	Facial paralysis or weakness	___Yes	___No
HEART	Coronary or heart attack	___Yes	___No
	Palpitations or irregular heart beat	___Yes	___No
	Hypertension	___Yes	___No
	Stroke	___Yes	___No
LUNGS	Shortness of breath	___Yes	___No
	Asthma	___Yes	___No
PSYCH.	History of psychiatric treatment?	___Yes	___No
	Are you taking mood altering drugs?	___Yes	___No
OTHER	Previous blood clots or phlebitis	___Yes	___No
	Bleeding disorders in self or family	___Yes	___No
	Blood transfusion	___Yes	___No
	Autoimmune diseases (lupus, rheumatoid arthritis)	___Yes	___No
	Unusual scarring or keloid formation	___Yes	___No
	Latex allergy	___Yes	___No
	Have you taken Accutane?	___Yes	___No
SOCIAL	Do you smoke?	___Yes	___No
	Do you use illicit drugs?	___Yes	___No
	Are you at risk for AIDS?	___Yes	___No