The Abel Center for Oculofacial Plastic Surgery, LLC
Medication/History Sheet
Today's Date:__________________

Patient Name: __________________________ Date of Birth: ______________________
Pharmacy: _____________________________ Telephone:________________________

Please Circle: Do you have any of the following medical problems?

Diabetes	Heart Condition	Lung Condition (asthma)
High Blood Pressure	Stroke	Allergies
Thyroid Disease	Cancer	Arthritis

Other____

Please Circle: Does anyone in your family have a history with the following?

Cataracts	Lazy or Crossed Eye	Heart Condition
Glaucoma	Diabetes	Thyroid Disease
Blindness	High Blood Pressure	

Other
____

List any previous surgeries: (i.e., pacemaker, bypass, stent)
____

List medications you are taking, including eye drops:______________________________
____

List any allergies to medications: ____

Latex Allergy: Yes or No

Blood Thinners: Yes or No – If yes, please list (i.e., aspirin, fish oil, vitamin E)
____

Review of Systems
Circle any symptoms you currently have or have had in the recent past:

Decreased Vision   Headache   Weight Loss   Fever   Muscle Weakness

Numbness   Easy Bruising/Bleeding   Nasal/Postnasal Discharge

Sinus Problems   Nervousness   Trouble Swallowing   Skin Lesions/Reactions

Other Describe:____