24022 Calle De La Plata, Ste. 180
Laguna Hills, CA 92653
Phone: (949) 458-3551 Fax: (949) 206-1179

PERSONAL INFORMATION

*First name: _____ Middle initial: _____ *Last name: _____

*Person filling out this form: _____

*Gender: _____ Marital Status: Married / Divorced / Single / Widow / Seperated

Last 4 digits of SSN#: _____ *Date of Birth: _____ Age: _____

*Height: _____ ft _____ inches *Weight: _____ pounds (Please be as accurate as possible)

*Home Phone: _____ Cell Phone: _____ Work Phone: _____

*We will call you on the weekday before your surgery. What is the best number to contact you?
_____ Home / Cell / Work

*Email Address: _____

*Address: _____ *Apt/Unit #: _____

*City: _____ *State: _____ *Zip Code: _____

*OK to leave a voice message if you are unavailable? O Yes O No

*Do we have permission to give your medical information to another person(s)? O Yes O No
If yes please list the person(s) name and relationship: _____

*Primary language: _____ *Interpreter needed: O Yes O No

EMERGENCY CONTACT: *First name: _____*Last name: _____

*Phone number: _____ *Relationship to you: _____

*Is this person your driver? O Yes O No If no, please list driver's name and phone number:
_____

*Do you have an Advance Health Care Directive O Yes O No
If not, would you like information? O Yes O No
(Advance directive is a general term that refers to your oral or written instructions about your future medical care in the event hat you become unable to communicate those instructions. Should you have an Advance Directive, you may provide a copy for your record but as a provider of outpatient services, it is the policy of this facility that Advance Directives will **NOT** be honored. For more information, please contact the surgery center. In the unlikely event that you are transferred to a hospital, your Advance Directive will accompany you.)

*Employment Status: Full Time / Part Time / Unemployed / Retired / Student

INSURANCE NFORMATION

*Is this visit the result of a motorvehicle or work related incident? O Yes O No

*Please list type of PRIMARY insurance (ex: Medicare, Blue Shield, etc.): _____

*Policy # / ID #: _____ Group # (if applicable): _____

*Policy holders relationship to patient: _____

*Please list type of SECONDARY insurance (if applicable): _____

*Policy # / ID #: _____ Group # (if applicable): _____

PRIMARY CARE PHYSICIAN

*Name: _____ *Phone Number: _____

VISIT INFORMATION

Surgeon/Doctor: _____ Surgery Date: _____ O Do not know

What operation are you having? (Please circle one) Site? Right or Left or Not Applicable

Ophthalmology Retina Pain Podiatry Dermatology/Plastics Other

What type of operation? (Please circle one)

Cataract Extraction with Lens Pterygium Excision with Graft Refractive Lens Exchange

Corneal Transplanct Other Unknown

PATIENT INFORMATION

Have you or a member of your family had any problems associated with a previous surgery or anesthesia, such as nausea, vomiting, Malignant Hyperthermia, or Pseudocholinesterase Deficiency? O Yes O No

If yes, please explain: _____

Have you been diagnosed with a drug resistant organism such as

*MSRA (Methicillin-Resistant Staphylococcus Aureus)? O Yes O No

*VRE (Vancomycin-Resistant Staphylococcus Aureus)? O Yes O No

Do you need mobility aids? O Yes O No If yes, specify: _____

*Have you ever been told after surgery that you were a difficult intubation? O Yes O No

Have you traveled to an Ebola-affected area within the last 30 days ? O Yes O No

(Currently Guinea, Liberia, Sierra Leone, Nigeria, Spain, Senegal, Dallas, Texas, or New York City, NY)

If yes, where did you travel? _____

ALLERGIES, MEDICATIONS AND SURGERIES

*Do you have any drug/medication allergies? O Yes O No

If yes, please list medication and reaction

_____

_____

*Are you allergic to latex? O Yes O No If yes, what is the reaction?_____

*Do you have any food allergies (peanuts, shellfish, egg yolks, sulfite, gluten)? O Yes O No

If yes, name the allergy and reaction: _____

*Do you have any envirionmental allergies? O Yes O No

If yes, please list and give reaction: _____

*Do you take any medications O Yes O No
(*including over the counter or herbal medications, vitamins/supplements or diet pills*)?

List Medications Below	Dosage	Units/Mg	How often taken/Times a day

***If you need more space for medications, please list them on the back of this form or on a separate paper

*Have you been instructed by your physician to stop taking any medication prior to surgery (for example Plavix, Coumadin, Anti-Inflamatories or Aspirin) ? O Yes O No

If yes, date you stopped the medication: _____ and please list the medication(s) that you stopped taking_____

*Have you had any surgeries/procedures? O Yes O No
(including plastic or dental surgery, colonoscopy, and childhood surgeries such as a tonsillectomy)

If yes, please list type of surgery/procedure and the year performed.
(use back of the page if you need more space)

Type:_____Year: _____ Anesthesia Type: _____
Type:_____Year: _____ Anesthesia Type: _____
Type:_____Year: _____ Anesthesia Type: _____
Type:_____Year: _____ Anesthesia Type: _____
Type:_____Year: _____ Anesthesia Type: _____

*Do you have a preferred pharmacy? O Yes O No

*Name: _____ *Phone #: _____

*Have you ever taken a medication called Flomax? O Yes O No

MEDICAL HISTORY

Cardiovascular Assessment:

*Are you followed by a cardiologist? O Yes O No

If yes, please list doctor name:_____ Office contact number:_____

*Have you had high blood pressure? O Yes O No

*Do you have an irrregular heart rhythm? (Ex: Atrial Fibrillation, Tachycardia) O Yes O No

If yes, what type do you have?:_____

*Do you have angina or chest pain? O Yes O No

If yes, how often you you experience chest pains? _____

*Do you have any heart stents? O Yes O No Year implanted:_____ How many? _____

*Valvular Disease? (Excluding Mitral Valve Prolapse) O Yes O No

*Do you have a pacemaker or difibrillator? O Yes O No If yes, which device?_____

*Do you have high cholesterol? O Yes O No

*Do you have any other heart diseases? O Yes O No

If yes, please explain_____

Pulmonary Assessment:

*Sleep apnea? O Yes O No If yes, do you use a CPAP/BIPAP mask? O Yes O No

*Do you have pulmonary embolism or tuberculosis? O Yes O No

If yes, please explain: _____

*Do you have asthma? O Yes O No

*Do you have COPD? O Yes O No

*Do you have any other pulmonary disease? O Yes O No

If yes, please explain: _____

SOCIAL ASSESSMENT

*Level of physical activity?(Circle one) Regular Irregular Do not exercise

*Do you smoke cigarettes? O Yes O No O Quit (if so, what year did you quit?)_____

*Do you drink alcohol? O Yes O No O Quit/Recovery

If yes: how many drinks? _____ Per day, week, month or year: _____

*Do you use recreational drugs? O Yes O No If yes, which type: _____

MENTAL HEALTH ASSESSMENT:

*Do you have anxiety, depression or any other form of mental health conditions? O Yes O No

If yes, please explain: _____

Please add any additional psychiatric information for you or anyone in your immediate family:

_____

MEDICAL CONDITIONS: HISTORY

Dermatology:

*Do you bruise easily? O Yes O No

*Does your skin tear easily? O Yes O No

Neurological:

*Have you experienced any neurological conditions, including stroke, siezure, dizziness, fainting spells or loss of consciouness? O Yes O No

If yes, please explain: _____

*Have you had a stroke / CVA (cerebral vascular accident) / TIA (transient ischemic attack)? O Yes O No

If yes, when and are there any residual affects?_____

*Do you have glaucoma? O Yes O No

Endocrine:

*Do you have diabetes, thyroid disease, hypoglycemia or any other endocrine condition? O Yes O No

If yes, which type?_____

Blood Disorder:

*Do you have any blood or clotting disorders, including Deep Vein Thrombosis or pulmonary embolism? O Yes O No

If yes, please expain: _____

Liver:

*Have you ever been diagnosed with Hepatitis? O Yes O No If yes, which type?_____

Kidney/Urinary:

*Do you experience chronic renal failure, bladder or kidney disease/stones, incontinence, painful or difficult urination? O Yes O No If yes, please explain: _____

Gastrointestinal:

Do you have Gastro Esophagel Reflux Disease (GERD), heartburn, or hiatal hernia? O Yes O No

If yes, how often you do you have symptoms?_____

*Do you have Crohn's Disease / ulcerative colitis? O Yes O No

Muscular/Skeletal:

*Do you have lower back pain? O Yes O No

*Do you have chronic pain? O Yes O No

*Do you have arthritis? O Yes O No

*Do you have joint replacement or dislocation? O Yes O No

If yes, which joint and when? _____

Women Only:

*Are you pregnant? O Yes O No

Date of last menstrual cycle: _____

*Have you reached menopause? O Yes O No

Please list any other gynecological conditions or concerns that we should be aware of:

_____

Other Conditions:

*Do you, or have you ever had cancer? O Yes O No

If yes, which type: _____

Did you receive radiation treatments? O Yes O No

Did you receive chemotherapy treatments? O Yes O No

*Are there any other medical condiitons/concerns that we should be aware of? O Yes O No

If yes please explain: _____

_____

_____

PRE-VISIT INSTRUCTIONS

*If you use an inhaler, bring that with you.

*For cataract patients, please do not wear eye makeup.

*Your surgeon will provide specific instructions for care while recovering at home. In the event of any diffuculty, please call your surgeon.

*For the first 24 hours following surgery, do not engage in strenuous activities, do not drink any alcoholic beverages, do not drive and do not make any critical decisions.

*Co-insurance/deductable/copay payment is due on the day of surgery, if applicable.

*Make arrangements for someone to transport you home.

*The day before surgery, follow your physician's instructions regarding medication usage.

*Anesthesia patients: nothing to eat or drink (including water, gum or candy) after midnight the night prior to surgery unless otherwise instructed by your doctor or anesthesiologist (failure to follow the instructions may result in delay or cancellation of your procedure).

*Leave all valuables at home, except for your photo ID card, insurance cards, and any payments for the day of surgery.

*No gum chewing the morning of surgery.