**STEPHEN J. LAQUIS MD, FACS**

OPHTHALMIC FACIAL PLASTIC SURGERY SPECIALISTS, PA

**MEDICAL HISTORY / REVIEW OF SYSTEMS (Page 1 of 2)**

**NAME:**_____ **DOB:** _____

HEIGHT:_____ WEIGHT:_____

**Who is your primary care physician?** Name:_____ Ph:_____
**Who is your cardiologist?** Name:_____ Ph:_____
**Who is your pulmonologist?** Name:_____ Ph:_____
**Who is your endocrinologist?** Name:_____ Ph:_____

## REVIEW OF SYSTEMS: (Please check any that may apply to you. ) OR ☐ I do not have any problems

**CONSTITUTIONAL**
_____ Recent fevers/sweats
_____ Unexplained weight loss/gain
_____ Unexplained fatigue/weakness

**EYE HISTORY**
_____ Change in Vision
_____ Double Vision
_____ Dry Eyes
_____ Baggy/Droopy Eyelids
_____ Tearing
_____ Eye Pain
_____ Eye Injury/Trauma
_____ Glaucoma
_____ Retinal Disease
_____ Cataract Surgery
_____ Contact Lenses
_____ Other _____

**ENT**
_____ Hard of Hearing
_____ Hay Fever/Allergies
_____ Sinus Problems
_____ Trouble Swallowing

**PULMONARY**
_____ Asthma
_____ **COPD**
_____ **Sleep Apnea CPAP? Yes or No**
_____ **Oxygen Use**

**MUSKULOSKELETAL**
_____ **Joint Replacement _____**
_____ Arthritis

**GASTROINTESTINAL**
_____ Heartburn
_____ Frequent Diarrhea
_____ Frequent Vomiting

**SKIN**
_____ Skin Cancer
_____ Basal Cell
_____ Squamous Cell
_____ Melanoma

**NEUROLOGIC**
_____ Headaches
_____ Seizures
_____ **History of Stroke/TIA**

**URINARY**
_____ Urinary Frequency

**PSYCHIATRIC**
_____ Anxiety
_____ Depression

**ENDOCRINE**
_____ Hypothyroid
_____ Hyperthyroid
_____ **Diabetes**
**Insulin Dependent / Oral (please circle)**

**CARDIOVASCULAR**
_____ **Cardiac Stents**
_____ Heart Attack
_____ Chest Pain
_____ **Atrial Fibrillation**
_____ **Irregular Heartbeat**
_____ High Cholesterol
_____ CHF
_____ High Blood Pressure
_____ **Valve Replacement**
_____ **Pacemaker**
_____ **Defibrillator**

**HEMATOLOGY/ONCOLOGY**
_____ **Blood disorders / clots**
_____ Anemia
_____ Cancer Type: _____

**INFECTIONS / AUTOIMMUNE**
_____ Hepatitis A, B, C (circle)
_____ HIV
_____ **History of MRSA, When_____**
_____ Lupus
_____ Sjogrens
_____ Rheumatoid Arthritis

**FEMALES**
_____ Pregnant? Yes or No

**TRANSPLANT**
_____ What organ? _____

**SURGICAL HISTORY**: Please list **all** previous surgeries:

_____ _____

_____ _____

_____ _____

Have you ever had any complications with anesthesia? ☐ Yes ☐ No _____

**FAMILY HISTORY**:
Diabetes ☐ Yes ☐ No _____
Arthritis ☐ Yes ☐ No _____
Eye disease ☐ Yes ☐ No _____
Cataracts ☐ Yes ☐ No _____
Glaucoma ☐ Yes ☐ No _____
Cancer ☐ Yes ☐ No _____

**SOCIAL HISTORY:**
Do you smoke? ☐ Current Smoker ☐ Former Smoker ☐ Never
Do you drink alcohol? ☐ Yes ☐ No How many drinks per day?_____
Do you use other recreational drugs? ☐ Yes ☐ No

_____ _____

Patient Signature / Representative Signature Date

**Reviewed by Provider: _____ Date:_____**

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**PATIENT MEDICAL HISTORY FORM (Page 2 of 2)**

**NAME:**_____**DOB:** _____

**Do you have any allergies? Please include the reaction:**

□ None □ Latex_____ □ Iodine_____ □ Penicillin_____ □ Sulfa_____ □ Codeine_____

□ Other_____

**Please list ALL MEDICATIONS you are currently taking, include SUPPLEMENTS and OVER THE COUNTER.**

| Medication Name | Dose | Frequency |
|---|---|---|
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**Are any of the medications that you are taking for the treatment of ADD/ADHD or Weight Loss? If YES list here:**

_____

_____ _____
Patient Signature / Representative Signature Date

**(OFFICE USE ONLY) Two Page History Reviewed:**

Initial / Date_____ □ No Change □ Updated:_____
Initial / Date_____ □ No Change □ Updated:_____
Initial / Date_____ □ No Change □ Updated:_____
Initial / Date_____ □ No Change □ Updated:_____
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Initial / Date_____ □ No Change □ Updated:_____

**Reviewed by Provider: _____Date:_____**