VERMONT COSMETIC EYE SURGERY

Blepharoplasty/Ptosis History

Describe in your own words the **symptoms** that you feel are caused by your eyelid(s) or eyebrow(s):

_____

_____

Detail **specific activities** that are impaired by your eyelid or brow problem (Ex: driving, reading, computer use):

_____

_____

Can you feel your upper eyelid skin resting on your eyelashes? Y _____ N _____
Do you use your fingers to lift your eyelid(s) or eyebrow(s)? Y _____ N _____
Do you experience ache or fatigue of your forehead muscles? Y _____ N _____

You have been aware of these visual problems for ***what duration of time***?
_____ years _____ months _____ weeks

Detail the ***times of day*** these problems occur:

_____

Rate the ***severity of the visual disturbances***:

|_____|_____|_____|_____|
Minimal Moderate Severe

Add any comments you feel are important for the doctor to consider regarding your symptoms due to eyelid or eyebrow problems:

_____

_____

Patient Name: _____ Date: _____/_____/_____

Patient Signature: _____

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OPHTHALMIC CONSULTANTS OF VERMONT
VERMONT LASER VISION
VERMONT COSMETIC EYE

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DOB: _____/_____/_____ DATE: _____/_____/_____

Referring Provider: _____ Primary Care Provider: _____

Eye Doctor: _____ Specialist: _____

Emergency Contact _____ Relation: _____ Phone Number: _____

REVIEW OF SYSTEMS Do you presently have any problems in the following areas?

Integument (skin)	YES	NO	Bones, Joints, Muscles, Arthritis	YES	NO
Eyes	YES	NO	Neurological (stroke)	YES	NO
Ears, Nose, Mouth, Throat	YES	NO	Lymphatic (lymph nodes/swelling)	YES	NO
Breasts	YES	NO	Hematopoietic (blood)	YES	NO
Neck	YES	NO	Cancer	YES	NO
Respiratory (lungs)	YES	NO	Endocrine (diabetes/thyroid)	YES	NO
Cardiovascular (heart/high blood pressure)	YES	NO	Allergic & Immunologic	YES	NO
Gastrointestinal (stomach/intestines)	YES	NO	Psychiatric	YES	NO
Genitourinary (genitals/kidneys/bladder)	YES	NO	Are you currently pregnant or breastfeeding?	YES	NO

If yes to any of the above, please explain: _____

_____

_____

List any medications you take: _____

_____

_____

List any surgeries you have had in the past: _____

_____

Do you have allergies to any medications? □ YES □ NO If YES, list the medications: _____

Do you have other allergies? □ YES □ NO If YES, list the allergy: _____

FAMILY HISTORY			**RELATIONSHIP TO PATIENT**
Glaucoma	YES	NO	_____
Macular Degeneration	YES	NO	_____
SOCIAL HISTORY			
Do you use cannabis?	YES	NO	
Do you use recreational drugs?	YES	NO	If YES, please specify: _____
Do you drink alcohol?	YES	NO	If YES, how many glasses a day?: _____
Do you smoke?	YES	NO	If YES, how many packs a day? _____

MARITAL STATUS: □ Single □ Married □ Divorced □ Widowed □ Other _____

PRESENT OCCUPATION: _____

What kind of work have you done in the past? _____

EDUCATION LEVEL: □ High School Graduate □ College Graduate □ Post Graduate Degree □ Other: _____

PREFERRED PHARMACY: _____ City/Town: _____

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