AZUL
Cosmetic Surgery and Medical Spa
PATRICK M. FLAHARTY, M.D.

****PLEASE TURN PAPER OVER AND SIGN BEFORE TURNING IT IN****

Patient Medical History **Date** _____

NAME _____ Date of Birth _____

SEX M _____ F _____ WEIGHT _____ HEIGHT _____ RACE _____

NATURE OF VISIT: _____

_____

REVIEW OF SYSTEMS: Please circle any of the following health problems, which you have or have had:

PLEASE CIRCLE YES OR NO

Cardiovascular
Y N Heart disease
Y N Heart attack
Date _____
Y N Angina
Y N Stroke Date _____
Y N High blood pressure

Endocrine
Y N Diabetes
Y N Thyroid

Skin Problems
Y N keloids/scarring

Ear/Nose/Throat
Y N Hearing Loss
Y N Wear hearing aids

Respiratory
Y N Lung Disease
Y N Chest

Gastrointestinal
Y N Ulcers
Y N Colitis/ Diverticulitis
Y N Liver/Hepatitis

genitourinary problems
Y N Kidney
Y N Bladder
Y N Prostate

Hemotologic
Y N Anemia
Y N Bleed/Bruise easily

Musculoskeletal
Y N Arthritis
Y N Joint Replacement

Neurologic/Psychiatric
Y N Seizures/Convulsions
Y N Alzheimer's
Y N Parkinson's disease
Y N Cancer

_____
_____
_____

Past Medical History: (Please list any surgery, injuries, operations or hospitalizations other than eyes)

_____

_____

If you circled diabetes above, are you ___ Diet-Controlled ___ Oral Medication-Controlled, ___ Insulin-Controlled?
When were you first diagnosed with diabetes? _____

Please list all medications that you are currently taking including eye drops and vitamins

Medication	Strength	How often	Medication	Strength	How Often

Are you allergic to any medications? ___Yes ___No (If yes, pleas list below)

_____

Are you Allergic to IODINE? Yes No DO YOU NEED PRE-OP ANTIBIOTICS Y N

PLEASE TURN PAPER OVER AND COMPLETE THE BACK SIDE

EYE HISTORY: have you ever been diagnosed with?

Y N Cataracts	Y N Macular degeneration
Y N Glaucoma	Y N Retinal disorders
Y N Diabetic Retinopathy	Y N Corneal Problems

EYE SURGERY/EYE TRAUMA— Please List: _____

_____

SOCIAL HISTORY: Smoke Y N Alcohol Y N

FAMILY HISTORY Please Circle Y (Yes) N (No)

Y N Cancer	Y N Diabetes	Y N Hypertension	Y N Retinal Detachment
Y N Heart disease	Y N Glaucoma	Y N Retinal disorders	

Primary Medical Doctor _____

Are you currently taking blood-thinning medication? List _____

Have you had an EKG in the last 6 months? If yes, where? _____

Patient Signature _____