



Dr. Amina Husain, MD

www.OculaPlastics.com

Patient Information

Name:		Sex:		Age:		Birth Date:	
Address:		City:		State:		Zip:	
Email:		Cell Phone:		Home Phone:			
How did you hear about us?				Marital Status:			
Primary Care Physician:				Physician Phone:			
Address:		City:		State:		Zip:	
Preferred Pharmacy:				Pharmacy Address:			
Emergency Contact:		Phone:		Relationship:			

Medical History

When was your most recent physical examination?					
What is your estimate of your general health?	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	
What is your stress level?	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low	<input type="checkbox"/> No stress!	
Do you HAVE or HAVE YOU EVER HAD?	YES	NO		YES	NO
Do you have HIV/AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	Is there a chance you are pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Hep B?	<input type="checkbox"/>	<input type="checkbox"/>	Are you breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Hep C?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have Hepatitis of any origin?	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have an allergy to tape?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any autoimmune conditions?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have high/low blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please circle.		
Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much per week?		
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much per day?		
Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list.		
Do you have an electrical implant such as a pacemaker or defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain.		
Do you have any prosthesis such as heart valve, artificial joints or breast implants?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain.		
Have you ever had an adverse reaction to anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain.		
Do you have any medication allergies?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list.		
Have you ever had an adverse reaction to corticosteroids (Prednisone, Dexamethasone, etc.) such as headaches, hallucinations, emotional instability, personality changes etc.?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain.		
Have you ever had an adverse reaction to benzodiazepines (Midazolam, Ativan/Lorazepam, Halcion/Triazolam, Valium/Diazepam, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain.		
Do you have any mental health conditions that you are diagnosed with currently or in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain.		
Please list all past operations:					
Please list all medications and supplements:					
Please state your goals for this procedure:					
What is your time frame for surgery?	<input type="checkbox"/> ASAP	<input type="checkbox"/> 1-3 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> Information Only	

I certify that the above information is true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____

