RESET FORM

eyeHEALTH associates
AMBULATORY SURGERY CENTER

170 Maple Road Williamsville, NY 14221

PATIENT HISTORY & INFORMATION

Name: _____ Date of Birth: _____

Current Height: ___ ft. _____ in. □Male □Female Current Weight: _____lbs.

Emergency Contact: Name_____ Relationship _____ Phone _____

For NY State Reporting: **RACE Options**: circle one: **W**-White, **B**-Black/African American, **A**-Asian, **H**-Native Hawaiian/Other Pacific Islander, **O**-Other, **U**-Patient Declined/Unknown

HOSPITALIZATIONS/SURGERIES (Include cardiac procedures, angioplasty, stents, cataract surgery, etc.)

	DATE	SURGERY OR REASON FOR HOSPITALIZATION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Have you or any family members ever experienced problems while under anesthesia such as a high fever or irregular heartbeat? □ Yes □ No

If Yes, please state what happened: _____

_____

WOMEN: □ I no longer menstruate. □ I do menstruate and understand I will be required to have a urine pregnancy test prior to surgery in order to receive IV sedation.

I do menstruate however I am □actively using birth control, □not sexually active, □infertile.

CURRENT MEDICATIONS (include herbal/over the counter medicine and vitamins, etc.)

	Name of Medication	Dose or Strength	How Often Taken?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____

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MEDICATION ALLERGIES and REACTIONS

☐ **No known allergies**

☐ **Yes, I have an allergy to:**

Medication/Substance/Food Allergy **Type of Reaction**

1. ____________________________ ____________________________________
2. ____________________________ ____________________________________
3. ____________________________ ____________________________________
4. ____________________________ ____________________________________
5. ____________________________ ____________________________________
6. ____________________________ ____________________________________

Do you have or have you had any of the following? **Please circle Y or N**

High Blood Pressure	Y	N	Kidney Disease	Y	N	Cancer	Y	N
Heart Attack	Y	N	Hemodialysis	Y	N	Arthritis	Y	N
Irregular Heartbeat	Y	N	Liver Problems	Y	N	Stroke	Y	N
Rheumatic Fever	Y	N	Hepatitis/Jaundice	Y	N	Seizures	Y	N
Chest Pain	Y	N	Asthma	Y	N	AIDS or HIV	Y	N
Cardiac Pacemaker	Y	N	Wheezing	Y	N	Thyroid Problem	Y	N
Reflux	Y	N	Difficulty Breathing	Y	N	Sinus Problems	Y	N
Heartburn	Y	N	Emphysema	Y	N	Anxiety	Y	N
Head Injury	Y	N	Difficulty Hearing	Y	N	Easy Bleeding	Y	N
Neck Pain	Y	N	Post Nasal Drip	Y	N	Back Problem	Y	N
Migraine Headaches	Y	N	Productive Cough	Y	N	Difficulty Lying Flat	Y	N
Type 1 Insulin Dependent Diabetes	Y	N	Easy Bruising	Y	N	Dizziness	Y	N
Type 2 Non-Insulin Dependent Diabetes	Y	N	Substance Abuse	Y	N	**Have you ever smoked?** How much: _______ Number of years: __ Quit date: _________	Y	N

Patient/Guardian Signature: ___________________________________ Date______________

****If patient does not sign his/her own legal documents please attach legal documentation of agent**

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SURGERY CENTER USE ONLY: TO BE COMPLETED ON SURGERY DAYS:

FIRST Eye Surgery:

☐No changes to above.

☐Changes/Additions to above:____

Nurse Signature:____________________________________ Date: _________________

SECOND Eye Surgery:

☐Only change to above is previous eye surgery.

☐Changes/Additions to above:_____________________________________

Nurse signature:______________________________________ Date: _______________

THIRD Eye Surgery:

☐Only change to above is previous eye surgery.

☐Changes/Additions to above:_____________________________________

Nurse signature:______________________________________ Date: _______________