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Oculofacial Plastic, Cosmetic and Reconstructive Surgery
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Patient History

Name: _____ Date: _____

What is your main concern? _____

Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)? No Yes

If YES, please explain: _____

Have you ever had any eye surgery? No Yes If YES, please provide date and surgical procedure: _____

Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)? No Yes

If YES, please explain: _____

Have you ever had any surgery (other than eye surgery)? No Yes

If YES, please provide date and reason: _____

Have you ever been hospitalized? No Yes

If YES, please provide date and reason: _____

Do you take any medications, vitamins or supplements? No Yes If YES, please indicate medication and dosage:

Do you have any drug or food allergies? No Yes If YES, please explain: _____

REVIEW OF SYSTEMS

Do you currently have any of the following problems:

Chronic fever, unexpected weight loss/gain, fatigue No Yes If YES, please explain: _____

Ear/nose/throat problems
(e.g., hearing loss, sinus problems, sore throat) No Yes _____

Cardiovascular (heart/blood vessels)
(e.g., chest pain, irregular heart beat) No Yes _____

Respiratory (lungs/breathing)
(e.g., shortness of breath, wheezing, coughing) No Yes _____

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Review of Systems Continued:

	No	Yes	If YES, please explain:
Gastrointestinal (stomach/intestines) (e.g., heartburn, abdominal pain, diarrhea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary (genitals/kidneys/bladder) (e.g., pain or discomfort, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Integument (skin) (e.g., rashes, excessive dryness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal (bones/joints/muscles) (e.g., muscle aches, joint pain, swollen joints)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic (e.g., numbness, weakness, headaches, paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine (e.g., feeling hot or cold, thyroid problems, prolonged tiredness)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hematopopoietic (blood) (e.g., bruise easily, anemia, swollen glands)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric (e.g., depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	_____

FAMILY and SOCIAL HISTORY

Do any medical or eye diseases run in your family?

(e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)

No Yes

If YES, please explain: _____

Do you smoke? If YES, how much? _____

Drink alcohol? If YES, how much? _____

Current occupation or previous profession: _____

Physician Comments:

M.D. Signature

Date

Updated Information:

