Email

Save

Print

Note: If you are using an internet email such as Yahoo or GMail, you will first need to SAVE your form. You will then need to send the saved form as an email attachment via your email client.

Kristin J. Tarbet, MD
Oculofacial Plastic, Cosmetic and Reconstructive Surgery
1810 116th Ave NE Suite D1
Bellevue, WA 98004

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:

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	**No**	**Yes**	**If YES, please explain**
Do you currently have any of the following problems:			
Chronic fever, unexpected weight loss/gain, fatigue	◉	○	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	◉	○	_____
Cardiovascular (heart/blood vessels) (e.g., chest pain, irregular heart beat)	◉	○	_____
Respiratory (lungs/breathing) (e.g., shortness of breath, wheezing, coughing)	◉	○	_____

Patient History, Page 2

Review of Systems Continued:

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

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:

sfgsdfgdgf

Physician Comments:

_____

M.D. Signature Date

Updated Information: