IRA VIDOR M.D.
OCULOPLASTIC SURGERY

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Date: _____

Name: _____ Age: _____ DOB: _____/_____/_____

Address: _____ City: _____ Zip: _____

Cell: _____ Home: _____ Email: _____

Primary Physician: _____ City: _____ Phone: _____

Primary Pharmacy: _____ City: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about Dr. Vidor? ☐ Practice Website ☐ Yelp ☐ Social Media ☐ Patient _____

☐ Family/Friend _____ ☐ Physician _____ ☐ Other _____

What is the reason for your visit today: _____

Severity of Concern(s) (Scale 1-10): _____ Have you consulted with other physicians about procedure(s) indicated above? ☐ Yes ☐ No

If yes, please describe your understanding of the procedure(s): _____

_____

Is this procedure a revision from a previous surgery? ☐ Yes ☐ No If yes, how many previous surgeries? _____

What is your "ideal time frame" for procedure(s) completion? _____

Occupation: _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Insurance Provider: _____ Policy #: _____

Group #: _____ Name of person insured: _____ SS#: _____

Eligibility Phone # ("For Providers"): _____ Copay Amount: _____

Secondary Insurance Provider: _____ Policy #: _____

Group #: _____ Name of person insured: _____ SS#: _____

Eligibility Phone # ("For Providers"): _____ Copay Amount: _____

HEALTH INFORMATION

Medical History:

Do you have any chronic medical problems? (Check all that apply.)

☐ High Blood pressure	☐ Heart Attack	☐ Psychiatric Diagnosis	☐ Asthma
☐ Heart Disease	☐ Chest Pain	☐ Bleeding Problems	☐ Cancer
☐ Heart Failure	☐ Diabetes	☐ Liver Disease	☐ HIV/ AIDS
☐ Seizures	☐ Kidney Disease	☐ Gastric Reflux	☐ Hepatitis
☐ Stroke	☐ Emphysema	☐ Stomach Problems	☐ Other: _____

Is there a personal or family history of anesthetic complications? ☐ Yes ☐ No

If yes, please explain: _____

Eye History:

Do you have any of the following eye problems? (Check all that apply.)

☐ Macular Degeneration ☐ Cataract ☐ Glaucoma ☐Other: _____

☐ Diabetic Eye Disease ☐ Dry Eye ☐ Vision Loss _____

Have you previously had the following? (Check all that apply.)

☐ Cosmetic Eyelid Surgery _____

☐ Functional Eyelid Surgery _____

Social History:

Do you currently use tobacco products? ☐ Yes ☐ No Do you currently use recreational drugs? ☐ Yes ☐ No

Alcohol Consumption: ☐ Never (Do not consume alcohol) ☐ Rare (1-2 drinks per week)

☐ Moderate (7-10 drinks per week) ☐ Heavy (Daily or more than 10 drinks per week)

Are you feeling hopeless about the future? ☐ Yes ☐ No

Do you currently have thoughts of harming yourself? ☐ Yes ☐ No

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Family History:

Do you have any family history of medical problems? (Please indicate family member.)

☐ High Blood pressure	☐ Heart Attack	☐ Psychiatric Diagnosis	☐ Asthma
☐ Heart Disease	☐ Chest Pain	☐ Bleeding Problems	☐ Cancer
☐ Heart Failure	☐ Diabetes	☐ Liver Disease	☐ HIV/ AIDS
☐ Seizures	☐ Kidney Disease	☐ Gastric Reflux	☐ Hepatitis
☐ Stroke	☐ Emphysema	☐ Stomach Problems	☐ Other: _____

Please list all prior operations:	Date:	List any complications:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Please list all medical conditions:	Date:	List any complications:
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Please list ALL medications and/or dietary supplements: (including prescriptions, over the counter medications, aspirin, vitamins and herbal supplements such as fish oil, saw palmetto, flax seed oil, and St. John Wort.)

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

Please list ALL allergies and describe reactions: (i.e. Shellfish, Latex, Penicillin, etc.)

Allergies:	Reactions:
1._____	_____
2._____	_____
3._____	_____
4._____	_____

REVIEW OF SYMPTOMS

Please answer the following to the best of your ability. Do you have any of the following conditions, illnesses, or symptoms? (Check all that apply.)

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Angina/Chest Pain
- ☐ Heart Failure
- ☐ Irregular Heartbeat
- ☐ Heart Murmur
- ☐ Heart Bypass Surgery
- ☐ Pacemaker
- ☐ Do you exercise?

NEUROLOGICAL
- ☐ Stroke
- ☐ Seizures
- ☐ Fainting
- ☐ Dizziness
- ☐ Headache
- ☐ Double Vision

URINARY
- ☐ Kidney Disease
- ☐ Urinary Disease
- ☐ Dialysis

REPRODUCTIVE (FEMALES)
Could you be pregnant? ☐ Yes ☐ No

Date of last menses (period): _____

RESPIRATORY
- ☐ Abnormal Chest X-Ray
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Recent chest infection
- ☐ Shortness of breath
- ☐ Shortness of breath at night
- ☐ Cough
- ☐ Cough with Sputum
- ☐ Sleep Apnea
- ☐ Use C-PAP Machine

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Taken Steroids

INFECTIOUS/ GASTROINTESTINAL
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Hiatal Hernia
- ☐ Heartburn

MUSCOLOSKELETAL
- ☐ Sciatica
- ☐ Herniated Disc
- ☐ Arthritis
- ☐ Rheumatoid
- ☐ Neck, Back, Arm, Leg Problem

HEMATOLOGIC/ ONCOLOGY
- ☐ Bleeding Tendency
- ☐ Easy Bruising
- ☐ Anemia
- ☐ Sickle Cell Disease
- ☐ Blood clots in legs
- ☐ Blood clots in lungs
- ☐ Radiation Therapy

SKIN
- ☐ Basal Cell Skin Cancer
- ☐ Melanoma
- ☐ Staph infection

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Psychiatric Care
- ☐ Obsessive Compulsive Disorder