

Is there a family history of glaucoma?	No () Yes ()
Do you wear contact lenses?	No () Yes ()
Do you have chronic bladder problems or kidney disease?	No () Yes ()
Have you passed bloody urine?	No () Yes ()
Have you ever been jaundiced?	No () Yes ()
Have you ever had hepatitis?	No () Yes ()
Do you have any history of hearing loss?	No () Yes ()
Have you ever had a broken nose?	No () Yes ()
Do you have chipped, loose, or capped teeth, dentures or braces?	No () Yes ()
Do you have any sores in you mouth that do not heal?	No () Yes ()
Are you prone to fever blisters?	No () Yes ()
Do you have any hoarseness or trouble swallowing?	No () Yes ()
Do you have any lumps in your neck?	No () Yes ()
Do you have stomach, bowel, or gallbladder problems?	No () Yes ()
Have you ever had bloody bowel movements?	No () Yes ()
Do you use alcohol?	No () Yes ()
If "Yes", how much? _____	
Do you use aspirin or other over-the-counter drugs?	No () Yes ()
Have you ever had thrombophlebitis or do your ankles swell?	No () Yes ()
Do you have any arm or leg numbness or weakness?	No () Yes ()
Do you have any physical disabilities or orthopedic problems?	No () Yes ()
Have you ever received radiation therapy?	No () Yes ()
Have you ever had psychiatric care or counseling?	No () Yes ()
Have you ever used "street" drugs?	No () Yes ()
Do you have any reason to believe that you have been exposed to the AIDS virus?	No () Yes ()
Is there any reason to believe that you are pregnant?	No () Yes ()

Height _____ Weight _____

Comments: _____

Patient's signature: _____

Reviewed by (surgeon): _____ Date _____

Reviewed by (anesthesia): _____ Date _____