RED RIVER EYE & LASER CENTER

THOMAS A. PLANCHARD, M.D.

PATIENT HISTORY

Date: ____________________________

Name: ______________________________________

Ht. ______ Wt. ______ Sex ______ Age ______

Allergies to Medications: ____

Medications presently taking: ____

____

Any previous surgical procedures: ____

____

Indicate any of the following problems you have experienced:

Lung:
- Bronchitis ______
- Emphysema ______
- Asthma ______
- Smoke ______
  - Packs per day ______ # of years ______

Vascular:
- High blood pressure ______
- Heart Attack ______
- Chest Pain ______
- Short of breath ______

Systemic:
- Diabetes ______
- Thyroid ______
- Arthritis ______
- Convulsions or Seizures ______
- Hepatitis/Jaundice ______
- AIDS/Exposure ______
- Stomach/Bowel Problems ______
- Bladder/Kidney Problems ______
- Presently Pregnant ______
- Problems with scarring ______

*Do you drink alcoholic beverages? _______ How often _______________

*Do you use recreational drugs? _______

*Any problems with anesthesia? _______

*Any problems with excess scarring or keloid formation? ________

*Any other problems we should know about: ________________________________

Patient Signature: ____