MICHAEL A. HOCHMAN M.D.,P.A.
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PATIENT HISTORY

DATE: _____ NAME: _____

FAMILY HISTORY: Among your blood relatives, is there a history of the following?

Condition (check if yes)	Relation	Condition (check if yes)	Relation
☐ Glaucoma		☐ Color Blindness	
☐ Cataracts		☐ Unexplained Vision Loss	
☐ "Lazy Eye" or Muscle Imbalance		☐ Diabetes Mellitus	
☐ Retinal Detachment		☐ Tumor or Cancer	
☐ Macular Degeneration		☐ Heart Disease	
☐ Night Blindness		☐ Bleeding Disorder	
☐ Stroke		☐ Other	

MEDICAL HISTORY: Do you now have, or have you ever had, any of the following?

Condition (check if yes)	Date of Onset	Condition (check if yes)	Date of Onset
☐ Diabetes Mellitus Treatment: diet control ☐ pills ☐ insulin ☐ Medical Complications: kidney ☐ vascular ☐ other ☐		☐ Cancer or Tumor Type: Location: Treatment:	
☐ High Blood Pressure Treatment:		☐ Thyroid Disease Type: underactive ☐ overactive ☐	
☐ Angina or Chest Pain		☐ Arthritis Type:	
☐ Heart Failure			
☐ Irregular / Rapid Heartbeat		☐ Numbness / Weakness	
☐ Cardiac Pacemaker		☐ Seizures	
☐ Heart Attack		☐ Depression / Nervous Breakdown	
☐ Stroke		☐ Blood Clots in Legs	
☐ Anemia		☐ Bleeding Disorders	
☐ Asthma		☐ Transfusions of Blood / Plasma	
☐ Emphysema and/or Bronchitis		☐ HIV Positive or AIDS	
☐ Pneumonia		☐ Skin Problems	
☐ Tuberculosis		☐ If female, are you pregnant?	
☐ Liver Disease or Jaundice		☐ Have you gained or lost more than ten pounds in the past year? Y or N If yes, list number and reason: Gained ☐ Lost ☐ pounds _____	
☐ Stomach or Duodenal Ulcer			
☐ Kidney Stones / Kidney Disease			
Allergies:			

Continued on Reverse

Name: _____ DOB: _____ DOS: _____

PATIENT HISTORY, Continued

Do you have any other medical problems? Y or N If yes, please describe:

Date of last general anesthesia: _____

Any anesthesia complications: Y or N If yes, please describe:

Any family history of anesthesia complications? Y or N If yes, please describe:

SOCIAL HISTORY:

Occupation: _____

Do you smoke cigarettes? Y or N If yes, how many cigarettes per day?_____

If no, and you smoked in the past, when did you quit?_____

Alcohol Intake: Y or N Amount: _____

REVIEWED

Nurse / Technician: _____ Date: _____

Physician: _____ Date: _____

ADDITIONAL HISTORY (for staff use):