Bryan Vekovius, M.D.
Oculoplastic Surgery and Neuro-Ophthalmology

Look Better, See Better

Registration Information

Call: 318-675-3733

Name*: _____ Age(years)* _____

Email: _____ Name of Referring Physician : _____

DOB _____ Name of Family Physician : _____

REVIEW OF SYSTEMS

Do you currently or have you ever had a problem with any of the following?

○ Yes ○ No		Ear Nose Mouth Throat
○ Yes ○ No		Cardiovascular (Heart/High Blood Pressure)
○ Yes ○ No		Respiratory (Lung/Breathing)
○ Yes ○ No		Gastrointestinal (Stomach/Intestines)
○ Yes ○ No		Genitourinary (Genital/Kidneys/Bladder)
○ Yes ○ No		Musculoskeletal (Muscle/Arthritis/Joints)
○ Yes ○ No		Integumentary (Skin)
○ Yes ○ No		Neurological Psychiatric (Depression/Nerves)
○ Yes ○ No		Endocrine (Diabetes/Thyroid/etc.)
○ Yes ○ No		Hematologic (Anemia/Bleeding Tendencies)
○ Yes ○ No		Lymphatic (Swelling)
○ Yes ○ No		Allergic/Immunologic

Do you have any allergies to any medication?

Currently taking any medication?List them

List any surgeries you have had:

FAMILY AND SOCIAL HISTORY:

Do any of your family members have any of the following diseases?

○ Yes ○ No	Glaucoma	○ Yes ○ No	Cataracts	○ Yes ○ No	Cancer
○ Yes ○ No	Retinal/Macular Degeneration	○ Yes ○ No	Arthritis	○ Yes ○ No	Heart Attack
○ Yes ○ No	Kidney Disease	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Stroke
○ Yes ○ No	Diabetes				
○ Yes ○ No	Other				

Do you smoke? ○ Yes ○ No How many packs per day? _____

Do you drink alcohol? ○ Yes ○ No How often? _____