raleigh eye and face

SURGERY SCREENING FORM

PATIENT NAME (First/last): _____ DOB: ___/___/_____

Complete the following about other doctors that you see if applicable:

How did you find out about Dr. Mettu?: _____

Primary Care Doctor (First/last name): _____

Do you take any of the following medications **YES or NO**: if yes please circle

Aspirin 81mg	**Eliquis (Apixaban)**	**Savaysa (Edoxaban)**
Coumadin (Warfarin)	**Xarelto (Rivaroxban)**	**Other Blood Thinner:**
Plavix (Clopidogrel)	**Pradaxa (Dabigatran)**	_____

Who prescribed the blood thinners? _____
Have you ever come off the blood thinners for a procedure? **YES / NO**
If you take aspirin: Do you take aspirin 81mg solely for primary prevention? **YES / NO**

Do you take any of the following medications **YES or NO**: if yes please circle

Exenatide (Byetta)	**Semaglutide (Ozempic,**	**Other GLP-1 Agonists:**
Liraglutide (Victoza)	**Wegovy, or Rybelsus)**	_____
Dulaglutide (Trulicity)	**Lixisenatide (Adlyxin)**	

Do you have a pacemaker? **YES / NO**

Any other implanted medical devices (i.e. spinal cord stimulator)? **YES / NO**

Details regarding implanted medical devices:_____

Do you smoke? **YES / NO**

Do you have any history of pulmonary conditions? **YES / NO**

Details regarding pulmonary conditions:_____

Do you use oxygen at home? **YES / NO**

Have you been hospitalized recently for breathing problems? **YES / NO**

Are you pregnant? **YES / NO**

Are you breastfeeding? **YES / NO**

How tall are you (inches)? _____

How much do you weigh (pounds)? _____

Have you had eyelid surgery before? **YES / NO**

Details regarding previous eyelid surgery:_____

Have you had eye surgery before (i.e. glaucoma surgery)? **YES / NO**

Details regarding previous eye surgery:_____

Have you had tear trough (under eye) filler before? **YES / NO**

Details regarding previous filler (date injected, type of filler, has it been dissolved etc): :_____

Which of the following procedures are you interested in (please circle)?

Upper blepharoplasty

Lower blepharoplasty

Laser resurfacing

Botox

If lower eyelid concerns, circle the primary issue:

Eye bags (puffiness)

Wrinkles and fine lines

Hollows

Discoloration

Please list your current medications including supplements (if you do not take any medication or supplements, please indicate that below rather than leaving this section blank):

Please list your medication allergies and other allergies (if no known medication allergies, please indicate that below rather than leaving this section blank):