Peninsula Health

BLEPHAROPLASTY PATIENT PRE OUTPATIENT ASSESSMENT

PATIENT DETAILS

Patient Name: _____

Address: _____

Suburb: _____ State: _____ Post Code: _____

Date of Birth: _____/_____/_____ Age: _____

MEDICAL (please tick)

Do you wear visual aids? ☐ Yes ☐ No

If so, what do you use?

☐ Glasses ☐ Contacts ☐ Other _____

Have you had your eyes tested in the last year? ☐ Yes ☐ No

Do you feel your eyes straining to see things? ☐ Yes ☐ No

Do you consciously need to raise your eyebrows so you can open your eyes wider to see more clearly? ☐ Yes ☐ No

Does your eyelid skin touch your eyelashes when you have your eyes open? ☐ Yes ☐ No

Do you feel that your eyelids are heavy? ☐ Yes ☐ No

Do you get a rash on your eyelids? ☐ Yes ☐ No

Do you have dry or watery eyes? ☐ Yes ☐ No

Have you had previous eyelid or eye surgery? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

If yes, how many cigarettes per day? _____

Do your eyelids interfere with your activities of daily living? Please specify:

_____

_____

_____

Peninsula Health

Please list all medications you are taking, including any drugs or medicine not prescribed by your doctor.

Name	Dose	Frequency

Thank you for this information.