

TODAY'S DATE: _____

MEDICAL HISTORY

Name: _____ Primary Doctor: _____ Referred by: _____

Activities/Hobbies: _____ Occupation: _____

I am interested in learning more about Laser Vision correction. Yes ___ No ___

Please list current medications below: (Please include aspirin and nutritional supplements)

Allergies to medication: _____

Please describe:

Past surgical history: _____

Major illnesses: _____

Family history of: (please circle below)

Glaucoma Diabetes Macular Degeneration Cataracts Crossed or Lazy Eye Cancer
Corneal Disease High Blood Pressure Retinitis Pigmentosa Heart Disease
Other _____ Adopted None of the above

Are you currently being treated for: Yes No

Diabetes Year diagnosed? _____
Heart Disease Specify below:
Angina Heart attack other _____
Cancer Specify below:
Respiratory disease Specify below:
Asthma Emphysema other _____
High Blood Pressure
If yes, year diagnosed _____
High Cholesterol
Arthritis (If yes, Osteo or Rheumatoid?)
Lupus
Vascular / Circulatory
Stroke / TIA month/year _____
Thyroid low high Graves
Headache migraine tension sinus
Stomach / Intestinal Disease
Kidney / Bladder
Liver Disease / Hepatitis A,B,or C
Skin ailments
Herpes/Shingles/Cold sores
AIDS/HIV
Neurologic / Depression / Manic
Environmental allergies
Chronic pain
Have you recently experienced?
Weight loss / gain

Have you ever had? Yes No

Cataracts
Glaucoma
Macular Degeneration
Retinal Detachment
Eye injury
Temporary vision loss
Migraine
Iritis
Crossed / Wandering eyes
Lazy Eye / Amblyopia
Eye surgery/Laser treatment
If yes please specify: _____

Any eye problem not listed above?

Please specify: _____

Yes No
Have you ever smoked?
If yes, packs per day? _____ For how long? _____
Alcohol dependency?
Drug dependency?
Are you currently pregnant?
Do you drive?

For office use only Changes in medical history

