MEDICAL HISTORY

PRINT PLEASE

Patient Name _____ DOB _____

Primary Care Physician _____ PCP Phone _____

OCULAR MEDICAL HISTORY

Glaucoma	Yes ☐ No ☐	Crossed Eyes	Yes ☐ No ☐	Blurred Vision	Yes ☐ No ☐
Cataracts	Yes ☐ No ☐	Lazy Eye	Yes ☐ No ☐	Double Vision	Yes ☐ No ☐
Macular Degeneration	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐	Floaters	Yes ☐ No ☐
Eye Injury	Yes ☐ No ☐	Dry Eyes	Yes ☐ No ☐	Tearing	Yes ☐ No ☐
Retinal Disease	Yes ☐ No ☐	Eyelid Problem	Yes ☐ No ☐	Eye Discharge	Yes ☐ No ☐
Blindness	Yes ☐ No ☐	Droopy Eyelid	Yes ☐ No ☐		

Do you wear glasses? Yes ☐ No ☐
Do you wear contacts? Yes ☐ No ☐ If Yes, what kind? _____
If Yes to glasses/contacts, are you interested in a Free Lasik Evaluation? Yes ☐ No ☐
Have you had Lasik? Yes ☐ No ☐

OCULAR SURGICAL HISTORY

Please list ALL previous eye surgeries: _____

_____

FAMILY EYE HISTORY

Does any family member have eye disease: Yes ☐ No ☐ If Yes, explain: _____

_____

SOCIAL HISTORY

Do you currently use tobacco products? Yes ☐ No ☐ Do you have a history of tobacco use? Yes ☐ No ☐
Do you drink alcohol? Yes ☐ No ☐ Social ☐

MEDICAL HISTORY

Type 1 Diabetes	Yes ☐ No ☐	Ear/Nose/Throat	Yes ☐ No ☐	Allergies	Yes ☐ No ☐
Yes? Last AIC reading	_____	Lung Disease	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
Blood sugar reading	_____	Ulcers/Digestive	Yes ☐ No ☐	Headaches	Yes ☐ No ☐
Type 2 Diabetes	Yes ☐ No ☐	Kidney Disease	Yes ☐ No ☐	HIV/AIDS	Yes ☐ No ☐
Yes? Last AIC reading	_____	Neurological	Yes ☐ No ☐	Hepatitis C	Yes ☐ No ☐
Blood sugar reading	_____	Psychiatric	Yes ☐ No ☐	Autoimmune	Yes ☐ No ☐
Hypertension (High BP)	Yes ☐ No ☐	Cancer	Yes ☐ No ☐	Are you pregnant?	Yes ☐ No ☐
Heart Disease	Yes ☐ No ☐	Thyroid	Yes ☐ No ☐		
History of Stroke	Yes ☐ No ☐				

MEDICATIONS

Please list names of **ALL** medications you are currently taking: _____

_____

Please list names of **ALL** medications you are allergic to: _____

_____

Patient Signature _____ Date _____

COMPLETE & GIVE TO TECHNICIAN