

Chart # _____

Name: _____ Date: _____

DOB: _____ Age: _____ Sex: M F Occupation: _____

Phone (Home): _____ Phone (Work): _____

Referral: _____ Primary Physician: _____

Are you interested in knowing if you are a candidate for Laser Vision Correction such as LASIK? Yes No

Past History

Allergies _____ Latex Sensitive? Yes No

Medications: (Please list eyedrops first) _____

Previous Eye History

Family Eye History

Glaucoma: Yes No _____ Yes No _____

Macular Degeneration: Yes No _____ Yes No _____

Diabetic Retinopathy: Yes No _____ Yes No _____

Retinal Detachment: Yes No _____ Yes No _____

Cataract: Yes No _____ Yes No _____

Eye Injuries: Yes No _____ Yes No _____

Previous Medical History (please list duration or date of onset, if known)

Diabetes: Yes No _____

Hypertension: Yes No _____

Heart Disease: Yes No _____

Asthma or Pulmonary Disease: Yes No _____

Thyroid Disease: Yes No _____

Arthritis: Yes No _____

Other: _____

Previous surgery or anesthesia? Yes No

If yes, please provide date and reason _____

Previous Hospitalization? Yes No

If yes, please provide date and reason _____

Do any medical diseases run in your family? (diabetes, high blood pressure, cancer, heart disease) Yes No

If Yes, please explain: _____

Social History

Do you smoke? Yes No If Yes, how much? _____

Do you drink alcohol? Yes No If Yes, how much? _____

Hobbies/Interests: _____

Review of Systems (Vision)

Any difficulty pursuing Hobbies/Interests due to vision? Yes No If Yes, Please explain: _____

Do you drive? Yes No If Yes, do you have visual difficulty when driving? Yes No

Trouble reading street signs? Yes No Trouble with glare or bright lights Yes No

Trouble with night vision? Yes No Other: _____

Do you have difficulty seeing to read? Yes No If Yes, please explain: _____

Review of Systems (Systemic)

Do you currently have any of the following problems?: **Yes** **No**

Allergy (hay fever, dust, dander, pollen, food, preservatives)

If Yes, please explain: _____

Heart problems (chest pain, irregular heart beat)

If Yes, please explain: _____

Constitutional (chronic fever, unexpected weight loss/gain, fatigue).....

If Yes, please explain: _____

Endocrine (Diabetes, Thyroid)

If Yes, please explain: _____

Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)

If Yes, please explain: _____

Genitourinary problems (pain or discomfort, blood in urine)

If Yes, please explain: _____

Ear/nose/throat problems (hearing loss, sinus problems, sore throat)

If Yes, please explain: _____

Hematologic/Lymphatic (bruising, bleeding)

If Yes, please explain: _____

Immunologic (frequent infections, HIV)

If Yes, please explain: _____

Integumentary (skin) problems (rashes, excessive dryness)

If Yes, please explain: _____

Musculoskeletal problems (muscle aches, joint pain, swollen joints)

If Yes, please explain: _____

Neurologic problems (numbness, weakness, headaches, paralysis)

If Yes, please explain: _____

Psychiatric problems (depression, anxiety)

If Yes, please explain: _____

Respiratory problems (shortness of breath, wheezing, coughing)

If Yes, please explain: _____

Date _____ Patient Signature _____

Date _____ Physician Signature _____