



LASER VISION CORRECTION CENTER

CONFIDENTIAL PATIENT HISTORY

The information that you give to us on this form will help us to give you better medical care.
Thank you for taking the time to fill this out.

Name: _____ Family Doctor: _____

Address: _____ City/State & Zip: _____

How did you hear of us? _____ Occupation: _____

Date of Birth: ___/___/___ Home Phone: (____)_____ Work Phone: (____)_____

Circle One of Each:

- Gender: Male Female
- Do you live alone?: Yes No
- Marital Status: Single Married Divorced Widowed
- Do You Smoke?: No Yes ____Packs per day for ____Years
- Do You Drink?: No Yes - If Yes, how much? _____
- Allergies: _____

Please circle below if you have any of the following eye or visual problems:

Difficulty Reading	Difficulty Driving	Poor Distance Vision	Glare
Double Vision	Eye Pain	Swollen Lids	Eye Discharge
Cataracts	Glaucoma	Lazy Eye	Excessive Tearing
Diabetic Eye Disease	Macular Degeneration	Flashing Lights	Floaters

Other: _____

Have you ever had eye surgery or laser surgery? No Yes (If Yes, please circle below)

Cataract Surgery	Glaucoma Surgery	Retinal Detachment Surgery
Laser for Glaucoma	Laser for Diabetes	Laser for Macular Degeneration
Eye Muscle Surgery	Eyelid Surgery	

Other: _____

Do you have any health problems? No Yes (If Yes, please circle)

Diabetes	Asthma	Emphysema	High Blood Pressure
Heart Attack	Angina	Stroke	Ulcer
Cartoid Disease	Thyroid Disease	Cancer	Rheumatoid Arthritis
Sickle Cell Disease	HIV/AIDS		

Other: _____

Have you had surgery other then eye surgery? No Yes (If Yes, Please List)

Have you had surgery any injuries or recent hospitalizations? No Yes (If Yes, Please List)

Do you take any medications regularly? No Yes (If Yes, Please List)

Do you suffer from or have you had (Select all that apply)

- | | | |
|--|----|-----|
| • Recent fever or extreme weight loss? | No | Yes |
| • Hearing loss, sinus problems or difficulty swallowing? | No | Yes |
| • Chest pain, irregular heart beat, or foot swelling? | No | Yes |
| • Shortness or breath, chronic cough or bloody sputum? | No | Yes |
| • Diarrhea, constipation, bloody stools or abdominal pain? | No | Yes |
| • Urinary problems or genital discharge? | No | Yes |
| • Rash, changing skin spots, breast masses or discharge? | No | Yes |
| • Memory loss, blackouts or weakness? | No | Yes |
| • Hallucinations or depression? | No | Yes |
| • Excessive urination, frequent thirst or fatigue? | No | Yes |
| • Bleeding problems, swollen lymph nodes or frequent infections? | No | Yes |
| • Other unusual symptoms: _____ | | |

Do you have relatives with eye or other medical problems? No Yes (If Yes, please circle)

Glaucoma	Macula Degeneration	Lazy Eye	Crossed Eyes
Diabetes	Night Blindness	Heart Disease	Hypertension
Sickle Cell Disease			

Other: _____

Reviewed by: _____ OD/MD Date: _____