New England Eye Center

Affiliated with Tufts University School of Medicine

LASIK & Cataract Center

CONFIDENTIAL PATIENT HISTORY

Name: _____ Family Doctor: _____

Address: _____ City/State & Zip: _____

Home Phone: **( )** _____ Cell/Work Ph: **( )** _____

***Please list best number to reach you during the day**

E-mail: _____

Date of Birth: ___/___/___

Circle One of Each:

- Gender: Male Female
- Do You Smoke?: No Yes _____Packs per day for _____Years
- Do You Drink?: No Yes - If Yes, how much? _____
- Allergies: _____

Contact Lenses:

- Last time you wore contact lenses: _____
- If you wore contacts in the past and were not successful, or are wearing them now with less success, please state reasons: _____
  _____

Please <u>circle below</u> 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
Infection	Halos	Other: _____	

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

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

Have you had surgery, injuries or recent hospitalizations? 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: _____		

Check all that apply:

☐ Children – Please state age(s): _____

☐ Pet(s) – What kind? _____

☐ Travel – Any trips planned within the next two months? _____

☐ Sports you participate in – Please list. Are any contact sports? _____

_____

☐ Computer Use – How many hours a day on computer? _____

☐ Reading – How many hours a day? _____

☐ Night Driving – How many hours a day? _____

Reviewed by: _____OD/MD Date: _____