

Name _____

Date of Exam _____

Date of Birth _____ Age _____

Referred by _____

Occupation _____

Family Doctor _____

What is the reason for your visit today? _____

Are you interested in? Laser Vision Correction YES NO Contact Lenses YES NO

Please indicate whether YOU have a history of the following by checking "YES" or "NO" next to each item.

Medical History

- | Yes | No |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> Lung disease (e.g. asthma, emphysema) |
| <input type="checkbox"/> | <input type="checkbox"/> Heart disease / murmur |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> | <input type="checkbox"/> Headaches / Migraines |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> HIV positive / AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> Allergic to penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> Allergic to sulfa |
| <input type="checkbox"/> | <input type="checkbox"/> Allergic to codeine |
| <input type="checkbox"/> | <input type="checkbox"/> Allergic to aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> Allergic to latex |
| <input type="checkbox"/> | <input type="checkbox"/> Allergic to _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Do you smoke? |
| <input type="checkbox"/> | <input type="checkbox"/> Do you use alcohol? |
| <input type="checkbox"/> | <input type="checkbox"/> Are you currently pregnant? |

Eye History

- | Yes | No |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> Cataract |
| <input type="checkbox"/> | <input type="checkbox"/> Retinal problems |
| <input type="checkbox"/> | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> | <input type="checkbox"/> Eye surgery |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ |
| | _____ |
| | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Do you wear glasses? |
| <input type="checkbox"/> | <input type="checkbox"/> Do you wear contact lenses? |

Surgical History

- | Yes | No |
|--------------------------|---------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> | <input type="checkbox"/> Heart |
| <input type="checkbox"/> | <input type="checkbox"/> Lung |
| <input type="checkbox"/> | <input type="checkbox"/> Vascular |
| <input type="checkbox"/> | <input type="checkbox"/> Neurosurgery |
| <input type="checkbox"/> | <input type="checkbox"/> Other _____ |

Other Medical History _____

Is there a history of any of the following in YOUR FAMILY?

Family History

- | Yes | No | Yes | No |
|--------------------------|---|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> Retinal problems |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> Blindness |
| <input type="checkbox"/> | <input type="checkbox"/> Cataracts | <input type="checkbox"/> | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> | <input type="checkbox"/> Lazy or crossed eyes | <input type="checkbox"/> | <input type="checkbox"/> Other _____ |

Please list any medications you are taking, including eye drops, and give the dosage for each.

1. _____
2. _____
3. _____
4. _____

5. _____
6. _____
7. _____
8. _____

Comment _____