Patient's Medical History

Date: ______________________

Name: ____________________________________

Date of Birth: ________________________________

Personal Medical Information: Do you have any of these conditions? If YES, check please

___ Gastrointestinal ___ Seizure ___ Diabetes Mellitus
___ Ear/Nose/Throat ___ Arthritis ___ Anemia
___ Skin ___ High Blood Pressure ___ Allergic/ Immunologic
___ Asthma ___ Ocular Surgeries ___ Depression
___ COPD Other ____________________________________

Are you in good health? Yes ___ No ___

List of MEDICATIONS: ____
____
____
____

Any allergic reaction reactions to medications or other substances? Yes ___ No___
If yes, please list. ____
____
____

Please check: Yes or No

Do you smoke? Yes ___ No ___ How much? ___________________________

Do you drink alcohol? Yes ___ No ___ How much? ___________________________

Do you use other substances? Yes ___ No ___

Do you have any of the following? If yes, please check.

___ Dry Eyes ___ Eye surgeries ___ Wear Glasses
___ Blurred Vision ___ Eye Injuries ___ Wear Contacts

Do you have family history of any of the following? If yes, please check.

___ Diabetes ___ Retinal detachment ___ High Blood Pressure
___ Macular Degeneration ___ Glaucoma ___ Cataracts

Name of primary physician: ______________________ **phone number:** _____________
Any eye problems at this time? Please explain.
____
____

Are interested in laser vision correction? Yes ___ No ___

Signature: ____________________________ **Date:** ____________________________