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Leaders in Eye Care

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LASIK MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ DOB: _____ DATE: _____

Name of Family/Personal Optometrist-Dr. _____Ph:_____

Date Of Last Medical Exam: / / Date Of Last Eye Exam: / /

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? If "yes", provide details.

EYES	YES	NO	EXPLAIN
Loss of vision	❑	❑	_____
Blurred vision	❑	❑	_____
Distorted vision	❑	❑	_____
Loss of side vision	❑	❑	_____
Double vision	❑	❑	_____
Dryness	❑	❑	_____
Mucous discharge	❑	❑	_____
Redness	❑	❑	_____
Sandy or gritty feeling	❑	❑	_____
Itching	❑	❑	_____
Burning	❑	❑	_____
Foreign body sensation	❑	❑	_____
Excess tearing / watering	❑	❑	_____
Occasional tearing	❑	❑	_____
Glare / light sensitivity	❑	❑	_____
Eye pain or soreness	❑	❑	_____

Medical History Con't -

Chronic infection of eye or lid ❑ ❑_____

Sties / Chalazion ❑ ❑_____

Fluctuating visual acuity ❑ ❑_____

Flashes / floaters in vision ❑ ❑_____

ALLERGIC / IMMUNOLOGIC

Head allergy symptoms ❑ ❑_____

Seasonal allergies ❑ ❑_____

Hay fever symptoms ❑ ❑_____

PAST HISTORY

Do you have any allergies to medications? ❑**YES** ❑**NO** if yes, please list_____

_____

Are you currently taking any medications? ❑**YES** ❑**NO** if yes, please list_____

_____

Are you currently using any eye drops? ❑**YES** ❑**NO** if yes, please list_____

Do you have any medical illnesses? ❑**YES** ❑**NO** if yes, please list_____

_____

Have you ever had surgery? ❑**YES** ❑**NO** if yes, please list_____

_____

Do you have any family history of medical problems? ❑**YES** ❑ **NO** if yes, please list_____

_____

List any eye surgeries, eye injuries, crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, or contact lenses worn? _____

_____

MEDICATIONS:

Are you taking any of the following medicines? –

	YES	**NO**
Accutane	_____	_____
Amiodarone (Cordarone)	_____	_____
(Pacerone)	_____	_____

PERSONAL HEALTH HISTORY

Please check any personal history of the following:

DISEASE	YES	NO
Glaucoma	❑	❑
Retinal Detachment/Tears/Disease	❑	❑
Arthritis	❑	❑
Diabetes	❑	❑
Gout	❑	❑
Lupus	❑	❑
Sjogrens Syndrome	❑	❑
Thyroid disease	❑	❑

History Reviewed by _____ Date:_____

Revised: 10/24/2007