LaserVue
EYE CENTER

PATIENT MEDICAL HISTORY / REVIEW OF SYSTEMS

Please Print with BLACK INK only

Name _____ Today's Date _____ / _____ / _____

Birthdate _____ / _____ / _____ Age _____ Sex *M* *F* Social Security # _____ / _____ / _____

Address _____ City _____ State ____ Zip _____

Home Ph.# (_____) _____ Cell (_____) _____ Work (_____) _____

Email address: _____

Eye Doctor _____ Last Eye Exam _____ Dr.'s Phone _____

Medical Doctor _____ Last Medical Exam _____ Dr.'s Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Medical History:

Do you have any allergies to medications? ☐ no ☐ yes, explain: _____

List the medications you're taking with dosage & frequency (including over-the-counter and home remedies):

_____

_____

_____

List and date all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Circle any of the following conditions that you have been diagnosed with (current or past): crossed eye, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections or injuries.

Family History: Please note any family history (blood relatives; living or deceased) for the following:

CONDITIONS	**NO**	**YES**	**Unsure**	**RELATIONSHIP TO YOU / EXPLAIN**
Blindness	❑	❑	❑	_____
Cataract	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Macular Degeneration	❑	❑	❑	_____
Retinal Detachment / Disease	❑	❑	❑	_____
Arthritis	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
Cardiovascular / Heart Disease	❑	❑	❑	_____
Kidney / Liver Disease	❑	❑	❑	_____
Thyroid Disease	❑	❑	❑	_____
Other(s): _____	❑	❑	❑	_____

---------- *CONTINUE ON BACK SIDE*----------

Doctor's Signature: _____ Date: / /

Social History *This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer.* ☐ Yes, I would prefer to discuss my social history information directly with my doctor. (check box)

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes

Do you drink alcohol? ☐ no ☐ yes If yes, type / amount / how long: _____

Do you use recreational drugs? ☐ no ☐ yes If yes, type / amount/ how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ Herpes ☐ HIV ☐ Syphilis

Hobbies: _____ Vision Interfering with Quality of Life? ☐ no ☐ yes Retired? ☐ no ☐ yes

REVIEW OF SYSTEMS Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss / Gain	☐	☐	☐
INTEGUMENTARY (Skin)	☐	☐	☐
NEUROLOGICAL			
Numbness / Weakness	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision / Halo	☐	☐	☐
Loss of Peripheral Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Itching / Burning	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain / Soreness	☐	☐	☐
ENDOCRINE			
Thyroid / Other Glands	☐	☐	☐
IMMUNOLOGIC	☐	☐	☐
PSYCHIATRIC			
Anxiety / Depression	☐	☐	☐

	NO	YES	?
EAR, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	☐	☐	☐
Sinus Problems	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema / COPD	☐	☐	☐
VASCULAR/CARDIOVASCULAR			
Diabetes	☐	☐	☐
Irregular Heartbeat	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Heartburn	☐	☐	☐
Chronic Diarrhea / Constipation / Vomiting	☐	☐	☐
GENITOURINARY			
Genitals / Kidney / Bladder (pain/discomfort)	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Muscle / Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC	☐	☐	☐
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐

If you answered **YES** to any of the above or have a condition not listed, please explain on a separate page & list medications.