

**LASER EYE SURGERY OF ERIE
HOWARD S. MANASSE. M.D.
ROBERT F. HAVERLY, M.D., F.A.C.S
BARRY L. GELLIS, O.D.**

Your Medical, Surgical, Family and Personal History

Patient Name _____ Date _____
Please take a few minutes to tell us about your significant past history.

Medical History

PAST AND CURRENT EYE PROBLEMS

**DO YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS
(CIRCLE AND TELL HOW MANY YEARS OR MONTHS)**

DIABETES(SUGAR)	ARTHRITIS	CANCER/TYPE	
HYPERTENSION	SKIN RASH OR DISEASE	NEUROLOGICAL STROKE/MS	
HEART DISEASE	THYROID DISEASE	ASTHMA EMPHYSEMA	
KIDNEY FAILURE	LUNG DISEASE	OTHER	LAST EYE EXAM YEARS ()

Surgical History

Past Surgeries and Significant Injuries (Date)

Past Eye Surgeries/Injuries (Date)

Current Medications

Oral or other systemic:

Eve Drops:

Allergies To Medications

PHARMACY PREFERENCE:

Family History

Has your Father (F), Mother (M), Sibling (S), or Grandparent (GP) had any of the following? Please Specify.

Arthritis _____	Thyroid Disease _____	Amblyopia (lazy eye) _____	Macular Degeneration _____
Migraine _____	Hypertension _____	Cancer _____	Retinal Detachment _____
Emphysema _____	Skin condition _____	Cataract _____	Other retinal disease _____
Stroke _____	Heart Disease _____	Glaucoma _____	Diabetes _____

Personal History

Do You Smoke? Hard of hearing? Unable to read?
Any special needs, such as wheelchair accommodation,
interpretation, or translation?
Please List: _____