LASER EYE SURGERY OF ERIE

Medical History Record

Patient Name (please print): ____ Date of Birth: ____________________________

Date of Last Eye Exam: __________________________________ Name of Previous Eye Doctor: ____

Do you have problems with any of these symptoms? If yes, please check box.

☐ Gastrointestinal	☐ Nervous System	☐ Neurological(stroke, ms)
☐ Ear/Nose/Throat	☐ Arthritis	☐ Cancer
☐ Cardiovascular	☐ Skin Disorder/Disease	☐ Thyroid Disease
☐ Respiratory	☐ Diabetes(sugar)	☐ Kidney Disorder/Disease
☐ Headaches	☐ Hypertension	☐ Other:

Past Surgical Procedures and Significant Injuries: (dates)

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Past Eye Surgery/Injuries: (dates)

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Allergic reactions to medications or other substances: ___Y ___N

If yes, please list medication and reaction: ____

Name of Primary Care Physician: ____ **Phone Number:** _________________________________

Current Medication: (Medication, Dosage)

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Eye Medication/Over the Counter Drops

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Family History: (F/father; M/mother; S/sibling; GP/grandparent)

☐ Arthritis	☐ Thyroid Disease	☐ Amblyopia(lazy eye)	☐ Macular Degeneration
☐ Migraine	☐ Hypertension	☐ Cancer	☐ Retinal Detachment
☐ Emphysema	☐ Skin Disease/Disorder	☐ Cataract	☐ Other Retinal Disease
☐ Stroke	☐ Heart Disease	☐ Glaucoma	☐ Diabetes

Do you smoke: Y / N **Unable to read: Y / N** **Hard of hearing: Y / N**

Any special need requirements: (wheelchair, interpreter, walker, guide/working dog)

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____________________________________ ________________________________ ________________

Patient Signature **Reviewed By** **Date**