**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.**

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|  | 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)** | | | | | |  |  | | **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Current Medication: (Medication, Dosage)** | | | | | | | | | |  |  | | **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**