LASER EYE SURGERY OF ERIE

For Office Use Only:
Date Received: _____
Reviewed By: _____

PATIENT'S MEDICAL HISTORY QUESTIONNAIRE – Page 1

Patient Name: _____ Date of Birth: _____

Date of Last Eye Exam: _____ Name of Previous Eye Doctor: _____

ALLERGIC REACTIONS TO MEDICATIONS OR OTHER SUBSTANCES: _____ Y _____ N

If yes, please list medication and reaction: _____

Name of **Preferred Pharmacy:** _____ Phone Number: _____

Do you currently wear glasses? _____ YES _____ NO

Do you currently wear contact lenses? _____ YES _____ NO

How old are your current glasses? _____

SOCIAL HISTORY

Do you engage in regular exercise? _____ YES _____ NO

Do you drink alcohol? _____ YES _____ NO If yes, how much: _____

Do you smoke? _____ YES _____ NO If yes, how much: _____

Do you use recreational drugs? _____Yes _____ No If yes, how often: _____

Have you ever smoked? _____ YES _____ NO When did you stop smoking? _____

Any Special Requirements: (Wheelchair, Interpreter, Walker, Service Animal): _____

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

___ Headaches / When did this start? _____

___ Tired Eyes / When did this start? _____

___ Double Vision / When did this start? _____

___ Burning / When did this start? _____

___ Redness / When did this start? _____

___ Itching / When did this start? _____

___ Loss of Vision / When did this start? _____

___ Floaters or Spots / When did this start? _____

___ Dryness / When did this start? _____

___ Blurred Vision at Distance / When did this start? _____

___ Blurred Vision at Near / When did this start? _____

___ Excess Tearing/Watering / When did this start? _____

___ Glare/Light Sensitivity / When did this start? _____

___ Amblyopia (Lazy Eye) / When did this start? _____

___ Sandy/Gritty Feeling / When did this start? _____

___ Drooping Eyelid / When did this start? _____

___ Infection of Eye/Lid / When did this start? _____

___ Crossed Eyes / When did this start? _____

___ Mucous Discharge / When did this start? _____

___ Fluctuation Vision / When did this start? _____

___ Distorted Vision (Halos) When did this start? _____

___ Eye Pain or Soreness / When did this start? _____

___ Loss of Side Vision / When did this start? _____

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PATIENT'S MEDICAL HISTORY QUESTIONNAIRE – Page 2

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

_____ Gastrointestinal	_____ Nervous System	_____ Neurological (Stroke)
_____ Ear / Nose / Throat	_____ Arthritis	_____ Cancer
_____ Cardiovascular	_____ Skin Disorder / Disease	_____ Thyroid Disease
_____ Respiratory	_____ Diabetes (Sugar)	_____ Kidney Disorder
_____ Memory Loss	_____ Heart Disease	_____ Seasonal Allergies
_____ Headaches	_____ Hypertension	_____ Other: _____

Past Surgical Procedures and Significant Injuries: (Dates)

_____
_____
_____
_____
_____

Past Eye Surgery / Injuries (Dates)

_____
_____
_____
_____
_____

Current Medication	Dosage	How often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10		

FAMILY HISTORY (F/FATHER; M/MOTHER; S/SIBLING; GP/GRANDPARENT)

_____ Arthritis	_____ Thyroid Disease	_____ Amblyopia (Lazy Eye)	_____ Macular Degeneration
_____ Migraines	_____ Hypertension	_____ Cancer	_____ Retinal Detachment
_____ Emphysema	_____ Skin Disease / Disorder	_____ Cataract	_____ Other Retinal Disease
_____ Stroke	_____ Heart Disease	_____ Glaucoma	_____ Diabetes

_____ Signature

_____ Date