Patient Name:_____ **Date of Birth:**_____

Primary Medical Doctor: **Last Eye Exam Date:** **Pharmacy:**_____

Medical History: Have you ever been diagnosed with **(please check all that apply)**:

Respiratory:
___Emphysema
___Asthma / Wheezing
___Shortness of breath
___COPD
___Sleep Apnea
___use Oxygen
___Cough/ Congestion

Eyes:
___Glaucoma
___Chronic Infections
___Dry Eyes
___Macular Degeneration
___Cataracts
___Seasonal Eye Allergies
___Excessive Tearing
___Eye Surgery
___Eye Injury
___Eye Pain/Soreness
___Glare/Light Sensitivity
___Double Vision

Kidney/Bladder:
___Painful Urination
___Dialysis
___Incontinence
___Frequent Urination

Gastrointestinal:
___Stomach/Bowel Problems
___Hernia or Hiatal Hernia
___Acid Reflux
___Ulcers
____Colonoscopy
___Constipation/Diarrhea

Cardiovascular:
___High Blood Pressure
___Heart Attack
___Irregular Heartbeat
___Racing Pulse
___Heart Stents
___Murmur
___Chest Pain
___Stroke
___Blood Clot Where_____
___Valve Problems
___Coronary Art. Disease
___Bruise or Bleed Easily
___CHF
___use Nitroglycerin
___Heart Surgery (Bypass/Stents)
___Pacemaker
___Blood thinners or Aspirin
___Anemia

Muscular/Skeletal:
Numbness / Pain To: ___Jaw/Neck
___Back ___Lower Extremities
___Joint replacement
Can you lay flat? ___Y ___N
___Arthritis
___Stiffness/Cramping

Endocrine:
___Diabetes: Controlled by
___Oral Medications
___Insulin
___Diet Controlled
___Liver Abnormalities
___Thyroid Problem (hypo/hyper)
___Jaundice / Yellow Skin

Neurological:
___Seizures
___Anxiety
___Depression
___Stroke
___Paralysis
___Hard of Hearing
___Hearing Aids
___Numbness
___Headaches
___TIA's
___Insomnia

Allergic/Immunologic:
___Sneezing
___Swelling
___Redness/Rash
___Itching
___Hives
___Lupus

General:
____Weight Loss
____Weight Gain
____Fever
____Heat Stroke
____Unusually Tired
_____**Weight lbs**
_____**Height**

Social:
___ Alcohol: _____drinks per day
___Smoker:_____packs/day

Skin: Have you ever had a positive skin test for TB? ____Y ____N if yes, Year:_____
Blood: Have you ever had a blood transfusion ? ____Y ____N if yes, Year:_____

Family History (Mother, Father, Grandparent, Sibling)
Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

ARE YOU ALLERGIC TO ANY MEDICATIONS: ☐ **YES** ☐ **NO**
If yes, what?_____

ARE YOU ALLERGIC TO ANYTHING ELSE? ☐ **YES** ☐ **NO**
If yes, what?_____

HAVE YOU EVER HAD A BAD REACTION TO ANY ANESTHESIA? ☐ **YES** ☐ **NO**
If yes, what?_____

Does your vision limit any activities of daily living? Circle any activities that you feel that you cannot perform as well as you would like because of decreased vision?

HAND WORK **READING** **WATCHING TV** **DRIVING**

DRIVING AT NIGHT **READING ROAD SIGNS** **OTHER:**_____

MEDICATIONS YOU TAKE: (Please include all herbal and over-the-counter medications)

NAME	STRENGTH	HOW OFTEN

Use separate sheet if necessary

SURGERIES YOU HAVE HAD WITH ANESTHESIA: **Use separate sheet if necessary**

WHAT FOR	APPROX. DATE	ANY COMPLICATIONS

Any other diseases, conditions or major medical problems we should know about?

_____

Patient Signature:_____ **Date:**_____

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR NEXT APPOINTMENT

REVIEWED WITH PATIENT _____ PATIENT SIGNATURE_____TECH INITIAL_____
Date

VISION SURGERY & LASER CENTER, LLC and/or WESTON EYE CENTER, PC
PATIENT HEALTH HISTORY Revised 8/11/2011