The Eye & Laser Center

MEDICAL HISTORY

Name: _____ Birthdate: _____ Sex: _____ Race: _____

Date: _____ Age: _____ Occupation: _____

Family Doctor: _____ Drug Allergies: _____

Preferred Pharmacy: _____

Please list any past eye surgeries:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please list any other past surgeries:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

Please list any past medical problems:

Check	*Yes*	*No*	
High Blood Pressure	☐	☐	_____
Diabetes (sugar)	☐	☐	_____
Stroke	☐	☐	_____
Seizure	☐	☐	_____
Heart Disease	☐	☐	_____
Asthma	☐	☐	_____
Emphysema	☐	☐	_____
High Cholesterol	☐	☐	_____
Cancer	☐	☐	_____
Arthritis	☐	☐	_____
Glaucoma	☐	☐	_____
Cataracts	☐	☐	_____
Retinal Detachment	☐	☐	_____
HIV	☐	☐	_____
Hepatitis	☐	☐	_____

Social History:

Do you use Tobacco? ☐ *Yes* ☐ *No* *Packs Daily:* _____

Do you drink Alcohol? ☐ *Yes* ☐ *No*

Please list your current medications:

Medication	*Mg*	*Dosage*	*Frequency*
Example: Lasix	25	1 pill	1 x per day
1.			
2.			
3.			
4.			
5.			
6.			

Medication	*Mg*	*Dosage*	*Frequency*
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			