

ONE *to* ONE LASIK

Medical History Questionnaire

Name: _____ Date: _____

Date of Birth: _____ Date of last eye exam: _____

List any medication (pills or eyedrops) you currently take (prescription and over-the-counter):

Do you have allergies to any medications? (Please Circle) Yes No

If YES, list the medications: _____

List all major illnesses or injuries: _____

List any operations you have had: _____

Do you currently have any of the following problems: *If "Yes" please provide details.*

| PROBLEM | YES | NO | EXPLANATION |
|--------------------------------------|-----|----|-------------|
| Blurred vision (with or w/o glasses) | | | |
| Burning of the eyes | | | |
| Crossed eyes, lazy eye | | | |
| Distorted vision | | | |
| Dryness of the eyes | | | |
| Double vision | | | |
| Drooping eyelid | | | |
| Eye pain or soreness | | | |
| Excess tearing/watering | | | |
| Foreign body sensation | | | |
| Fluctuating vision | | | |
| Floaters/Flashes of light | | | |
| Glare/Light sensitivity | | | |
| Halos or starbursts around lights | | | |
| Itching of the eyes | | | |
| Infection of eye or lid | | | |
| Loss of vision | | | |
| Loss of side vision | | | |
| Mucous discharge | | | |
| Redness of the eyes | | | |
| Sandy or gritty feeling in the eyes | | | |
| Tired eyes | | | |

Do you currently have any of the following problems: *If "Yes" please provide details.*

| PROBLEM | YES | NO | EXPLANATION |
|--|------------|-----------|--|
| Acne, warts, skin cancer | | | |
| Anxiety, depression, insomnia | | | |
| Asthma, emphysema | | | |
| Arthritis | | | |
| Allergies, hay fever, lupus, Sjogren's | | | |
| Heart problems/high cholesterol | | | |
| Anemia or other blood problems | | | |
| Diabetes or thyroid problems | | | |
| Fever | | | |
| Genital, kidney, bladder problems | | | |
| Sinus, ear infection chronic dry cough, dry mouth | | | |
| Stomach ulcers, intestinal disease | | | |
| Weight loss/weight gain (unwanted) | | | |
| FAMILY HISTORY | YES | NO | M=mother, F=father, S=sibling, GP=grandparent |
| Arthritis | | | |
| Blindness | | | |
| Cancer | | | |
| Diabetes | | | |
| Glaucoma | | | |
| Heart disease or high blood pressure | | | |
| Kidney disease | | | |
| Lupus | | | |
| Stroke | | | |
| Thyroid disease | | | |
| Other | | | |

| | | | |
|---|-----|----|---|
| Do you live alone? | Yes | No | (Please circle) |
| Do you drive? | Yes | No | |
| Do you have visual difficulty when driving? | Yes | No | |
| Do you use a computer? | Yes | No | |
| Do you currently wear contact lenses? | Yes | No | If yes, how long? |
| Have you ever tried to wear contact lenses? | Yes | No | |
| Do you currently wear glasses? | Yes | No | If yes, how old is your current prescription? |
| Do you drink alcohol? | Yes | No | |
| Do you smoke? | Yes | No | |
| Have you ever had a blood transfusion? | Yes | No | |
| Do you use any illicit drugs (marijuana, cocaine, etc.) | Yes | No | |

Physician Signature:

Date:

Reviewed/Changes/Additions: