ONE to ONE
LASIK
Cataract Surgery
Eye Care

Eye History & Medical History Form

Date_____

Name:_____ Age: _____ Date of Birth: _____

Email Address:_____ Preferred Language: ❑ English ❑ Other_____

Reason for Visit:_____

Pharmacy Name and Address and/or Phone: _____

DRUG ALLERGIES, OTHER ALLERGIES & REACTIONS: (if any, please describe, or enter "none")		
Past Eye Problems or Condition:	**Past Eye Surgeries:**	**Current Eye Medications/Drops:**
Past Medical Problems or Conditions:	**Past Surgeries:**	**Current Systemic Medications:**

FAMILY HISTORY:

❑ Diabetes ❑ Stroke ❑ Blindness ❑ Macular Degeneration ❑ Arthritis
❑ Cancer ❑ TB ❑ Cataracts ❑ Retinal Disease ❑ Lazy Eye
❑ Heart Disease ❑ Kidney Disease ❑ Glaucoma ❑ High Blood Pressure

❑ Other/Explanation:

SOCIAL HISTORY:

Smoking Status: ❑ Non-Smoker ❑ Smoker _____ packs/day _____ years ❑ Quit (when)_____			
Alcohol ❑ Yes ❑ No	If Yes: How Much?		
Social Drugs ❑ Yes ❑ No	Drugs Used:		
	How Much?	How Long?	When Quit?

(CONTINUED ON BACK)

ONE to ONE
LASIK
Cataract Surgery
Eye Care

Eye History & Medical History Form (continued)

Name:_____

REVIEW OF SYSTEMS

EYES

Previous Surgery	❑ Yes	❑ No
Contact Lens	❑ Yes	❑ No
Pain	❑ Yes	❑ No
Double Vision	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No
Macular Degeneration	❑ Yes	❑ No
Dry Eyes	❑ Yes	❑ No
Flashes	❑ Yes	❑ No
Floaters	❑ Yes	❑ No

EAR, NOSE & THROAT

Hard of Hearing	❑ Yes	❑ No
Ringing in Ears	❑ Yes	❑ No
Vertigo	❑ Yes	❑ No

CARDIOVASCULAR

Chest Pain	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No
Fainting Spells	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No
Irregular Heart Beat	❑ Yes	❑ No
Difficulty Lying Flat	❑ Yes	❑ No

CONSTITUTIONAL

Fatigue/Weakness	❑ Yes	❑ No
Fever	❑ Yes	❑ No
Weight Gain/Loss	❑ Yes	❑ No

RESPIRATORY

Cough	❑ Yes	❑ No
Congestion	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No
Asthma	❑ Yes	❑ No

GASTROINTESTINAL

Heartburn	❑ Yes	❑ No
Nausea/Vomiting	❑ Yes	❑ No
Jaundice/Hepatitis	❑ Yes	❑ No

GENITO-URINARY

Pain/Difficulty	❑ Yes	❑ No
Blood in Urine	❑ Yes	❑ No
History of Kidney Stones	❑ Yes	❑ No
History of STD's	❑ Yes	❑ No

PSYCHIATRIC

Anxiety/Depression	❑ Yes	❑ No
Mood Swings	❑ Yes	❑ No
Difficulty Sleeping	❑ Yes	❑ No

ENDOCRINE

Increased Thirst	❑ Yes	❑ No
Increased Hunger	❑ Yes	❑ No
Increased Urination	❑ Yes	❑ No
Thyroid Problems	❑ Yes	❑ No

BLOOD/LYMPHNODES

Easy Bruising	❑ Yes	❑ No
Gums Bleed Easily	❑ Yes	❑ No
Prolonged Bleeding	❑ Yes	❑ No
Heavy Asprin Use	❑ Yes	❑ No

MUSCULO-SKELETAL

Stiffness	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No
Joint Pain/Swelling	❑ Yes	❑ No

SKIN

Rash/Sores	❑ Yes	❑ No
Lesions	❑ Yes	❑ No
Hives/Eczema	❑ Yes	❑ No

NEUROLOGICAL

Seizures	❑ Yes	❑ No
Weakness/Paralysis	❑ Yes	❑ No
Numbness	❑ Yes	❑ No
Tremors	❑ Yes	❑ No

IMMUNOLOGIC

Hives/Itching	❑ Yes	❑ No
Congestion	❑ Yes	❑ No
Runny Nose	❑ Yes	❑ No
Sinus Pressure	❑ Yes	❑ No

OTHER:

Physician Comments:

M.D.