PROVISION LASER EYE CENTER MEDICAL HISTORY

Date: _____ Name: _____
Date of Birth: _____ Phone: _____ Approx Height_____ Weight_____
Primary Physician: _____ Endocrinologist: _____

EYE HISTORY: Have you or do you currently have any of the following:

☐**NONE** ☐Cataract Surgery (approx. date _____)
☐Glaucoma ☐Macular Degeneration ☐Dry Eyes ☐Floaters / Flashing lights
☐Blurred Vision ☐Eye pain, aching or burning ☐Retinal Detatchment ☐LASIK surgery
☐Itching, tearing, redness ☐Trouble seeing road signs ☐Difficulty with glare or halos around lights
Do you wear contact lenses? ☐Yes ☐No

REVIEW OF SYSTEMS: Check all that apply or check NONE

NEUROLOGICAL: ☐**NONE** ☐Stroke (date _____) ☐Temporary Vision Loss ☐Tremor ☐Alzheimers
RESPIRATORY: ☐**NONE** ☐Asthma ☐COPD ☐Emphysema ☐Shortness of Breath ☐Bronchitis
☐Chronic Cough
EAR, NOSE, THROAT: ☐**NONE** ☐Swollen Glands ☐Vertigo ☐Seasonal Allergies ☐Sinus Problems
ENDOCRINE: ☐**NONE** ☐Diabetes ☐Hypothyroid ☐Hyperthyroid
CARDIOVASCULAR: ☐**NONE** ☐Heart attack (date _____) ☐Irregular Heartbeat ☐Angina
☐Pacemaker (date_____) ☐Chest Pain ☐Heart valve abnormality ☐Aortic stenosis
GASTROINTESTINAL / SKIN: ☐**NONE** ☐Ulcers ☐Hernia ☐Lesions ☐Rash
GENITOURINARY: ☐**NONE** ☐Kidney Stone ☐Kidney Failure ☐Hernia ☐Liver Problems
MUSCULOSKELETAL: ☐**NONE** ☐Joint Pain ☐Muscle Weakness ☐Back Pain ☐Arthritis
HEMATOLOGIC / LYMPHATIC: ☐**NONE** ☐Blood Disorder ☐Anemia ☐Leukemia ☐Hepatitis ☐Cancer _____
PSYCHIATRIC: ☐**NONE** ☐Depression ☐Anxiety ☐Panic Attacks
OTHER: _____

CURRENT MEDICATIONS: ☐**NONE**

Name	**Dosage**	**Name**	**Dosage**

Do you use any eye drops? ☐Yes ☐No If yes, please list: _____

SURGERIES: Please list all past surgical procedures and approximate date ☐**No previous surgeries**

Surgery	**Date**	**Surgery**	**Date**

ALLERGIES: ☐**NONE**

_____
_____
_____
_____

Allergic to latex? ☐Yes ☐No **Allergic to eggs?** ☐Yes ☐No

FAMILY HISTORY: ☐**NONE** ☐Glaucoma ☐Cataracts
☐Diabetes ☐Retinal Detachment ☐Macular Degeneration

Do you smoke cigarettes? ☐Yes ☐No Drink Alcohol? ☐Yes ☐No
Hobbies / Activities: _____ Occupation: _____
Do you live: ☐Alone ☐With spouse ☐Care center ☐Other:_____