

VISTA EYE SPECIALISTS ~ PATIENT MEDICAL HISTORY

Patient Name: _____ Birthdate: _____ Primary Care Doctor: _____

Please answer the following questions about your medical status and history. Check any conditions / symptoms you have had in the past or currently have.

MEDICAL HISTORY

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes Type _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Auto-Immune Diseases | <input type="checkbox"/> Organ Transplant _____ |
| <input type="checkbox"/> Other _____ | | |

OCULAR HISTORY

- | | | |
|--|---|---|
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Trauma/Injury to Eye |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Contact Lens |
| <input type="checkbox"/> Corneal Disease _____ | <input type="checkbox"/> Strabismus / Eye Muscle Problems | Type: _____
Hours worn daily: _____ |
| <input type="checkbox"/> Other _____ | | |

LIST ANY EYE SURGERIES OR OTHER SURGERIES: _____

LIST ANY MEDICATIONS / INSULIN / EYE DROPS YOU ARE CURRENT TAKING: _____

LIST ANY DRUG OR FOOD ALLERGIES: _____

Do you take BLOOD THINNERS (i.e. Aspirin, coumadin)? Yes No

ARE YOU CURRENTLY TAKING OR HAVE YOU TAKEN FLOXMAX? Yes No

ARE YOU ALLERGIC TO LATEX? Yes No **HEIGHT:** _____ **WEIGHT:** _____

PLEASE REVIEW AND MARK ANY PROBLEMS YOU MAY HAVE NOW, OR HAVE HAD IN THE PAST:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Chronic Fever | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Skin Rashes |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Urinary pain / discomfort | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Coughing | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Abnormal Bleed / Bruise |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Unexpected weight gain / loss (circle one) |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Excessive Skin Dryness | <input type="checkbox"/> Other: _____ |

FAMILY HISTORY

Medical / Eye Diseases in Family (check all that apply)

- Diabetes
- High Blood Pressure
- Cancer
- Glaucoma
- Macular Degeneration
- Other _____

SOCIAL HISTORY

- Yes No Do you drive?
- Yes No Do you have trouble with night vision?
- Yes No Do you smoke? How much? _____
- Yes No Do you drink? How much? _____
- Yes No Women: Could you be pregnant?
- Yes No Are you interested in finding out about Laser Vision Correction?

I have fully reviewed this questionnaire and answered all questions to the best of my knowledge. I am aware that my answers could affect my health care, or that patient for whom I am responsible.

Patient/Responsible Party Signature: _____ Date: _____