

# 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: _____<br>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 FLOMAX?**  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: \_\_\_\_\_