

Medical History

Name: _____

Date: _____

Family History

Please indicate if a family member (blood relative) has any of the following:
Diabetes _____ Glaucoma _____ High Blood Pressure _____ Macular Degeneration _____
Other _____

Personal History

Amblyopia (lazy eye) _____ Arthritis _____ Alcohol _____ Asthma _____
Cancer (specify type) _____ Cataracts _____ Diabetes _____ Dry Eyes _____
Dyslexia _____ Emphysema _____ Glaucoma _____ Heart Disease _____
HIV Positive _____ High Blood Pressure _____ Keratoconus _____ Migraine _____
Multiple Sclerosis _____ Seizures _____ Sinus _____ Thyroid _____ Parkinson's _____
Smoker _____ Strabismus (cross-eyed) _____ Macular Degeneration _____
Other (please specify) _____

Name of Primary Care Physician: _____

Medications

- 1).
- 2).
- 3).

Drug Allergies

- 1).
- 2).
- 3).

What is the reason for your visit today? _____

Have you had eye injuries or surgeries? **YES / NO**

If yes, what type and when? _____

Have you had any other surgeries? **YES / NO**

If yes, what type and when? _____

Do you wear contact lenses? **YES / NO** If yes, what type? _____

When did you last wear your contact lenses? _____

What kind of contact lens solution do you use? _____

Are you interested in? **Glasses Contact lenses Laser Vision Correction**

These are areas of concern for me:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Fine lines and wrinkles | <input type="checkbox"/> Hair on face | <input type="checkbox"/> Freckles |
| <input type="checkbox"/> Major lines around nose and mouth | <input type="checkbox"/> Hyperpigmentation | <input type="checkbox"/> Dryness |
| <input type="checkbox"/> Rough texture of skin | <input type="checkbox"/> Brown Spots | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Tired looking skin | <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Sagging Skin |

Our Laser Can Help Correct These Concerns!