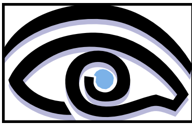

LASERCARE EYE CENTER

Medical History Form

PATIENT NAME:______________________________________ DATE:_________________________

Medical History

Primary Reason for today's visit: ____
____

List all eye conditions, eye surgeries or major eye injuries: ____
____

Do you have any of the following medical conditions? ☐High blood pressure ☐High cholesterol ☐Diabetes ☐Thyroid disease ☐Stroke ☐Migraines

List any other medical conditions?____
____
____

List all medications you are allergic to: ____

List all eye medications you are taking:____
____

List all other medications you are taking:____

Review of Systems

If you have any of the following medical problems or symptoms, please tick "yes" and explain below.

System	Condition	
Endo.	Diabetes	☐Yes
	Frequent urination	☐Yes
	Thyroid disease	☐Yes
Const.	Unexpected weight loss or weight gain	☐Yes
	Fever or chills	☐Yes
Cardio.	Heart disease	☐Yes
	Pace maker	☐Yes
	Bypass surgery or angioplasty	☐Yes
	Congestive heart failure or heart attack	☐Yes
	Chest pain	☐Yes
Resp.	Lung disease	☐Yes
	Asthma or emphysema	☐Yes
	Tuberculosis	☐Yes
	Shortness of breath	☐Yes
	Productive cough	☐Yes
GI	Stomach or digestive disorder	☐Yes
	Ulcers	☐Yes
	Abdominal pain	☐Yes
	Chronic diarrhea or constipation	☐Yes

System	Condition	
G/U	Urinary disorders	☐Yes
	Pain or discomfort on urination	☐Yes
	Kidney stones	☐Yes
	Blood in urine	☐Yes
Skin	Skin disorders	☐Yes
	Changes in skin color	☐Yes
	Eyelid masses	☐Yes
	Rash	☐Yes
Heme.	Anemia	☐Yes
	Bleeding trouble	☐Yes
	Blood transfusion	☐Yes
ENT	Hearing loss	☐Yes
	Sinus disorder	☐Yes
M/S	Muscle weakness	☐Yes
	Arthritis	☐Yes
Psych.	Psychiatric disorders	☐Yes
	Depression	☐Yes
Neuro.	Neurologic disorders	☐Yes
	Paralysis	☐Yes
	Stroke	☐Yes
	Numbness or tingling	☐Yes
	Headache	☐Yes
	Migraines	☐Yes

If you answered "yes" to any of the above problems, please explain below: ______________________________
____

Family History

Do you have a family history of? ☐Diabetes ☐High blood pressure ☐Blindness ☐Glaucoma ☐Macular Degeneration ☐Cataracts ☐Retinal Detachment ☐Vision loss ☐Amblyopia (lazy eye)

If so, please explain:____

Social History

Do you smoke? ☐Yes ☐No If yes, how many packs a day_________________ How long have you smoked____________

Do you drink alcohol? ☐Yes ☐No If yes, how much____________________Have you ever used illegal drugs? ☐Yes ☐No

The Other Side of this Form is for OFFICE USE ONLY

FOR INTERNAL OFFICE USE ONLY

LaserCare Eye Center

Medical Review Form

Name:____
Account #_______________ DOB:_____________________

Insurance

Primary Care Physician

Allergies: ☐ NKDA

Family History:

Social History:

OPHTHALMIC DIAGNOSES

MEDICATIONS

MEDICAL DIAGNOSES

Review of Systems

Ophthalmic History Review

Ophthalmic history reviewed. Changes noted above.

Date: ____________________ Reviewer:_______________
Date: ____________________ Reviewer:_______________
Date: ____________________ Reviewer:_______________
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Date: ____________________ Reviewer:_______________
Date: ____________________ Reviewer:_______________

Medical History Review

Medical history (including PMH, Social Hx, Allergies, Family Hx, Review of systems) reviewed. Pertinent changes noted above.

Date: ____________________ Reviewer:_______________
Date: ____________________ Reviewer:_______________
Date: ____________________ Reviewer:_______________
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