Dr. Joseph Ceravolo  Auburn Lasik & Eye Institute Dr. Lisa Daniel

Name _____ Date _____

**MEDICAL HISTORY FORM**

1. Primary Care Doctor: _____

2. Do you now or have you ever had: When diagnosed?

a. Diabetes…….. Yes___ No___ _____

Treatment: diet control___ oral agents___ Insulin___ other___

Medical Complications : kidney____ vascular____ eye____

b. Heart Attack…… Yes___ No___ _____

Angina or Chest Pain…… Yes___ No___ _____

Heart Failure…….. Yes___ No___ _____

Irregular or Rapid Heart Beat…….. Yes___ No___ _____

Cardiac Pacemaker Inserted…….. Yes___ No___ _____

c. High Blood Pressure…… Yes___ No___ _____

d. Stroke or TIA…….. Yes___ No___ _____

e. Anemia…… Yes___ No___ _____

f. Asthma…….. Yes___ No___ _____

Emphysema and/or bronchitis…….. Yes___ No___ _____

Pneumonia…… Yes___ No___ _____

Tuberculosis…… Yes___ No___ _____

g. Liver Disease or Jaundice…… Yes___ No___ _____

h. Stomach or Duodenal Ulcer…… Yes___ No___ _____

i. Kidney Stones/Other Kidney Diseases…….. Yes___ No___ _____

j. Arthritis (if yes, list type)…… Yes___ No___ Rheumatoid:_____ Osteo:_____

k. Cancer or Tumor…… Yes___ No___ _____

Type_____ Treatment:_____

l. Thyroid Disease…….. Yes___ No___ _____

Underactive_____ Overactive_____ Treatment:_____

m. Migraine…… Yes___ No___ _____

n. Blood Clot in Legs…… Yes___ No___ _____

o. Transfusions of Blood or Plasma…….. Yes___ No___ _____

p. HIV Positive, AIDS……. Yes___ No___ _____

q. Other Medical Problems……... Yes___ No___ _____

Please Describe:_____

_____

3. Are you allergic to any medications or foods? Yes___ No___

If yes, please describe substance(s), with type of reaction:_____

_____

4. Please list medications you are using at present in the spaces provided below:

| EYE MEDICATIONS | | | | ALL OTHER MEDICATIONS | | |
|---|---|---|---|---|---|---|
| Name | Dose | Freq. | Eye | Name | Dose | Freq. |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

5. Date of last eye exam_____Eye Doctors Seen_____

Have you ever had any eye injuries? Yes___ No___ If yes, please describe injuries and dates:_____

_____

6. Have you ever had any previous eye surgery or laser treatment? Yes___ No___ If yes, please give name of operations and dates:_____

_____

7. What other operations have you had? Please give types and dates.

_____

_____

8. Among your blood relatives, is there a history of any of the eye disease (glaucoma cataracts etc)? Please list:.

_____

Patient Signature_____