Patient Health History

Patient Name: ________________________________ Date: ____________________

Phone: ____________________ Date of Birth: ________________ Age: ____________________

Are you currently wearing contacts? □ Yes □ No

If Yes: □ Hard □ Soft □ Disposable
If No: □ Never Worn
Last Worn: ____________

How Long: ____________

Are you currently wearing glasses? □ Yes □ No
If Yes: □ Single Vision □ Bifocal □ Trifocal □ Progressive

How Long: ____________

Are you interested in Lasik? □ Yes □ No

Known Allergies:

Patient Eye History

Please check **ALL** that apply
Y=Yes, N=No, FH=Family History, M=Medications

	Y	N	FH	M
Glaucoma				
Cataracts				
Lazy Eye				
Dry Eye				
Retinal Problems				
Eye Infections				
Eye Injuries				
Cataract Surgery				
Laser Surgery				
Refractive Surgery				

If Yes: □ RK □ AK □ PRK □ LASIK □ CK □ LASEK

Patient Medical History

Please check **ALL** that apply
Y=Yes, N=No, FH=Family History, M=Medications

	Y	N	FH	M
Diabetes				
High Blood Pressure				
Heart Problems				
Respiratory Problems				
Thyroid				
Cholesterol				
Autoimmune Disease				
Headaches				
Ears/Nose/Throat				
Pregnant/Lactating				
Arthritis				
COPD				
Keratoconus				
Other				

Please Specify:

Are you currently taking any EYE medications or drops? □ Yes □ No
If yes, please list all eye medications and/or drops

____

Please list any other medications you are currently taking:

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Patient Signature: ______________________________ Date: ____________________