TIDEWATER EYE CENTERS, P.C.

LVI PATIENT MEDICAL HISTORY FORM

NAME_____AGE_____BIRTHDATE _____ TODAY'S DATE _____

CURRENT OPTOMETRIST:_____ **OCCUPATION:** _____

EYE HISTORY *(Please check if applicable)*

_____ Cataract
_____ Glaucoma
_____ Tumor
_____ Injury
_____ Retinal Problems
_____ Laser Treatments
_____ Herpes Simplex of the eyes or lids
_____ Surgery
_____ Disease
_____ Amblyopia
_____ Dry Eye
_____ None

Are you taking any eye medications? _____ Yes _____ No (If yes, please list _____)
What % do you use your eyes for close work? (reading, computer) _____%
What % do you use your eyes for distance? (driving, sports) _____%
When do you wear your glasses/contact lenses? _____
How old is your current prescription: _____ Is it stable: ____ Yes____ No (If No, when did it last change? _____)
How do you currently read? _____ With Correction/Reading Glasses _____ Without Correction
What are your hobbies? _____
What do you hope to accomplish with Vision Correction Surgery? _____

FAMILY EYE HISTORY *(Please check if applicable)*

_____ Blindness (Relationship - _____)
_____ Cataract (Relationship - _____)
_____ Glaucoma (Relationship - _____)
_____ None

CONTACT LENS HISTORY

What type of contact lenses do you wear? _____ Soft _____Hard _____ Gas Permeable
When did you last wear your contact lenses? _____ How many year? _____

YOUR MEDICAL HISTORY

_____ High Blood Pressure
_____ Thyroid Condition
_____ Cancer
_____ Other
_____ Headaches/Migraines
_____ Hay Fever
_____ Stroke
_____ Do you form Keloids? (Abnormal Scarring)
_____ Heart Disease
_____ Asthma
_____ NONE

****If you have any of the following Medical conditions, you may not be a candidate for Laser Vision Correction.**

_____ Hepatitis
_____ HIV / AIDS
_____ Auto Immune Disease
_____ Diabetes
_____ Nursing (currently)
_____ Pregnant (currently)
_____ Lupus
_____ Arthritis
_____ Eczema
_____ Rheumatoid Arthritis

CURRENT LIST OF MEDICATIONS (Including non-prescription drugs and vitamins)

Medication	What are you taking this for?
_____	_____
_____	_____
_____	_____

DO YOU HAVE ALLERGIES TO MEDICATIONS? _____Yes _____ No
If yes, please explain reaction. _____

If you answer YES to any of the questions below, please call our office at (757) 483-0400 to discuss.

Do you have a Pacemaker or Automated Internal Cardiac Defibrillator? _____ Yes _____ No
Are you taking Amiodarone (Heart medication)? _____Yes _____No
Are you taking Accutane (Acne medication)? _____Yes _____ No
Are you taking Imitrex (Migraine medication)? _____ Yes _____No