Spectrum Lasik

Medical History

Your Information

1. What is your name?: _____ Today's date: _____

Medical History

2. Primary care doctor: _____ Tel: _____

3. Do you now, or have you ever had: Diagnosis date:

a. Diabetes . . . . . Yes ☐ No ☐ _____
Treatment: diet control ☐ oral agents ☐ insulin ☐ other ☐
Medical complication: kidney ☐ vascular ☐ eye ☐ other ☐

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: rheumatoid ☐ osteo ☐ . . . . . Yes ☐ No ☐ _____

k. Cancer or tumor . . . . . Yes ☐ No ☐ _____
Type: _____
Treatment: _____

l. Thyroid disease: underactive ☐ overactive ☐ . . . . . Yes ☐ No ☐ _____
Treatment: _____

m. Migraine . . . . . Yes ☐ No ☐ _____

n. Blood clot in legs . . . . . Yes ☐ No ☐ _____

o. Bleeding disorders . . . . . Yes ☐ No ☐ _____

p. Transfusions of blood or plasma . . . . . Yes ☐ No ☐ _____

q. HIV positive, AIDS. . . . . Yes ☐ No ☐ _____

r. Other medical problems . . . . . Yes ☐ No ☐ _____
Please describe: _____

4. Are you allergic to any medications or foods? . . . . . Yes ☐ No ☐ _____
If yes, please describe substance(s), with type of reaction: _____

Medications

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

Eye medication(s)				All other medication(s)		
Name	Dose	Frequency	Eye	Name	Dose	Frequency

Please turn over

Eye Care History

6. Eye doctors seen: _____
   Have you ever had any eye injuries? . . . . . Yes ☐ No ☐
   If yes, please describe injuries and dates: _____

7. Have you ever had any previous eye surgery or laser treatment? Yes ☐ No ☐
   If yes, please give name of operations and dates: _____

8. What other operations have you had? Please give types and dates: _____

Systems Review

9. Are you **currently** having problems with any of the following. Please complete and give details:
   a. Unexplained weight gain or loss greater than 10 lbs . . . . . Yes ☐ No ☐ _____
   b. Fever, chills, night sweats . . . . . Yes ☐ No ☐ _____
   c. Decreased vision, eye pain, double vision . . . . . Yes ☐ No ☐ _____
   d. Decreased hearing, ringing in ears . . . . . Yes ☐ No ☐ _____
   e. Nasal congestion, nose bleeds, sinus congestion . . . . . Yes ☐ No ☐ _____
   f. Hoarse voice, sore throat . . . . . Yes ☐ No ☐ _____
   g. Chest pains or heaviness, shortness of breath, leg pain when walking, ankle swelling, irregular heartbeat . . . . . Yes ☐ No ☐ _____
   h. Cough, wheezing, coughing up blood or sputum . . . . . Yes ☐ No ☐ _____
   i. Heartburn, nausea, stomach pain, diarrhea, constipation . Yes ☐ No ☐ _____
   j. Problems with kidneys, urination, bladder . . . . . Yes ☐ No ☐ _____
   k. Skin rashes or lesions, breast lumps . . . . . Yes ☐ No ☐ _____
   l. Headaches, dizziness, muscle weakness . . . . . Yes ☐ No ☐ _____
   m. Joint Pain, stiffness, swelling . . . . . Yes ☐ No ☐ _____
   n. Depression, nervousness / anxiety . . . . . Yes ☐ No ☐ _____
   o. Lymph node swelling, infections . . . . . Yes ☐ No ☐ _____
   p. Itching, sneezing / allergy symptoms . . . . . Yes ☐ No ☐ _____

Social and Family History

10. a. Are you a smoker? Yes ☐ No ☐ cigarettes per day: _____ When did you stop? _____
    b. Alcohol use? None ☐ Social ☐ 2-3x week ☐ with dinner ☐ other ☐
    c. Occupation: _____ Live alone: Yes ☐ No ☐
    d. Exercise? None ☐ Occasionally ☐ Weekly ☐ Daily ☐
    e. Do you drive? . . . . . Yes ☐ No ☐ _____

11. Among your blood relatives, is there any history of any of the following? List: mother, father, sister, brother, etc.
    a. Glaucoma . . . . . Yes ☐ No ☐ _____
    b. Cataracts . . . . . Yes ☐ No ☐ _____
    c. "Lazy eye" or muscle imbalance . . . . . Yes ☐ No ☐ _____
    d. Retinal disease or macular disease . . . . . Yes ☐ No ☐ _____
    e. Migraine . . . . . Yes ☐ No ☐ _____
    f. Night blindness/color blindness . . . . . Yes ☐ No ☐ _____
    g. Unexplained vision loss . . . . . Yes ☐ No ☐ _____
    h. Diabetes mellitus . . . . . Yes ☐ No ☐ _____
    i. Tumor or cancer . . . . . Yes ☐ No ☐ _____
    j. High blood pressure . . . . . Yes ☐ No ☐ _____
    k. Heart disease . . . . . Yes ☐ No ☐ _____
    l. Bleeding disorder . . . . . Yes ☐ No ☐ _____

12. If applicable, are you pregnant? . . . . . Yes ☐ No ☐ _____

13. Interested in Laser Vision Refractive Surgery (LASIK)? . . . . . Yes ☐ No ☐ _____

Patient signature: _____ Doctor signature: _____ Technician signature: _____