Doctors For Visual Freedom Laser Center

Patient Information

Please Print Clearly **Date _____**

_____ _____/_____/_____ _____ **Male / Female**
Last Name First Name MI Date of Birth Age

_____ _____ _____ _____
Current Street Address City State Zip Code

Home Telephone ( ) _____ Email _____

Work Telephone ( ) _____ Cell ( )_____

Employer _____ Occupation _____

Employers Address _____

Emergency Contact _____ Telephone #_____Relationship _____

Social Security Number (SSN) _____ Married_____ Single_____ Widow_____ Other_____

How long have you been thinking about Refractive Surgery?_____

HOW DID YOU HEAR ABOUT US / WHO REFERRED YOU?
Your Primary Care Physician, Optometrist, Friend / Relative_____, Internet, Yellow Pages, Facebook, Website, Google, Yahoo, Dex Knows, Angie's List, Top Doc, Zoc Doc, Yelp, Other _____

Your Physician: Name _____MD/DO Address_____
City_____ State _____ Zip _____ Phone _____

Your Optometrist: Name _____MD/DO Address_____
City_____ State _____ Zip _____ Phone _____

What medications are you currently taking? _____
_____
Eye medications? _____
Allergies? _____
How old are your glasses? _____
How often does your prescription change? _____
Do you wear contact lenses? Yes / No
If yes, What type? Soft daily ____Soft Toric _____Soft extended ____Gas Permeable ____
Do you sleep in your contact lenses? Yes / No
If you wear reading glasses, have you tried Monovision Contact Lenses? Yes / No
How long have you worn lenses? _____
Please list any history of eye problems or eye surgery? _____
_____
_____
_____

Medical History:
Present Review of Systems (Do you currently have any problems in the following areas?)

High blood pressure (___yrs)	Y	N	Heart disease	Y	N
Stroke (when ____)	Y	N	Poor Circulation	Y	N
Diabetes (_____yrs)	Y	N	Bones, joints, muscles	Y	N
Rheumatoid Arthritis	Y	N	Constitutional (fever)	Y	N
Weight Loss/Gain	Y	N	Joint Pain	Y	N
Breathing problems	Y	N	Endocrine	Y	N
Skin problems	Y	N	Kidney Problems	Y	N
Headaches	Y	N	Migraines	Y	N
Cancer (type _____)	Y	N	Prostate disease	Y	N
Depression	Y	N	Neurological Systems	Y	N
Ear, Nose, Mouth, Throat	Y	N	Psychiatric	Y	N
Refractive Surgery	Y	N	Allergic/Immunologic	Y	N
Keratoconus	Y	N	Sinus congestion	Y	N
Eye Injury	Y	N	Dry throat/mouth	Y	N
Cataracts	Y	N	Chronic cough	Y	N
Macular Degeneration	Y	N	Chronic Bronchitis	Y	N
Retinal Problems	Y	N	Asthma	Y	N
Crusty eyelashes	Y	N	Emphysema	Y	N
Glaucoma	Y	N	HIV positive	Y	N
Crossed Eyes	Y	N	Gastrointestinal (stomach)	Y	N
Vision Loss	Y	N	Hay fever	Y	N
Drooping Eyelids	Y	N			

Other _____
_____

Past Medical History:
List all surgeries & hospitalizations you have had in the past
_____
_____
_____

Social History:
Do you use tobacco products? Yes No If so: _____packs per day
Do you drink alcoholic beverages Yes No If so: _____drinks per week
Single / Married / Divorced / Widowed

Family History: (circle and /or list any medical problems in your family)
Glaucoma / keratoconus or corneal transplant / diabetes / high blood pressure / crossed eyes / lazy eye / retinal problems / cancer / arthritis / gout / heart disease / kidney disease / lupus / stroke / thyroid / breathing problems / Other _____
_____

Is there anything else we should know about you and your general health?
_____
_____

Patient Signature _____ Date _____